THE MONTANA MEDICAID PROGRAM

State Fiscal Years 2007/2008

Report for the 2009 Legislature

A report by the Montana Department
of Public Health and Human Services

DEPARTMENT OF
PUBLIC HEALTH AND HUMAN SERVICES

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GOVERNOR

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January 5, 2009

Dear Legislators:

On behalf of the Department of Public Health and Human Services, I am pleased to transmit the Montana Medicaid Program Report to the 2009 Legislature.

The Report is divided into two sections.

The first section summarizes the Montana Medicaid Program mission and the activity for SFY 2007. It outlines such Medicaid matters as the SFY 2007 eligibility criteria for mandatory and optional populations; the actual enrollment of and benefits paid to the separate eligible populations; enrollment and expenditures by county; waivers by populations; the number of participating providers and claims they submitted; and a summary of the rate setting process.

The second section begins on page 30 and addresses the statutorily required Biennial reporting to the Legislature as contained in 53-6-110, MCA. That section details historic and future Federal Medicaid matching rates; SFY 2007 expenditures by eligible populations, by provider type; a 10 year history of expenditures and enrollment; a 10 year comparison of the growth in Montana Medicaid compared to the Health Care Price Index and the Consumer Price Index; cost containment measures; a chronology of major events in Montana Medicaid; and the Medicaid expenditure projections for the 2011 Biennium.

Over the past two years, the state's Medicaid Program has made great strides. Specifically, I would like to draw your attention to three very significant programs that are described in detail beginning on page 43 under Chronology of Major Events in Montana Medicaid.

The Medicaid Administrative Match Program (MAM) was created where contracted Montana Tribes are reimbursed with federal funds for allowable administrative costs related to the Medicaid State Plan or waiver service, as has been similarly done in the school based program. The Department also established the Home and Community-Based Services waiver for adults age 18 and over with severe disabling mental illness who, without the waiver, would be in nursing homes. Finally, an agreement was executed with the Chippewa Cree Tribe to facilitate the provision of Medicaid benefits to reservation residents.

We trust you will find the information contained in the Report useful, and if you have any questions or if we can provide additional information, please feel free to contact either myself at (406) 444-5622, or the Division Administrators at the phone numbers listed on page three of the Report.

Sincerely,

Anna Whiting Sorrell, Director

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Section I- Montana Medicaid Program Activity

Section II- Biennial Report

The Montana Medicaid Program is authorized under 53-6-101, Montana Codes Annotated, and Article XII, Section 3 of the Montana Constitution. The Department of Public Health and Human Services (DPHHS) administers the program.

Program Mission:

To assure that necessary medical care is available to all eligible Montanans within available funding resources.

Basic Objectives:

- To promote the maintenance of good health by Medicaid eligible persons
- To assure that Medicaid eligible persons have access to necessary medical care
- To assure that the quality of care meets acceptable standards
- To promote the appropriate use of services by Medicaid eligible persons
- To assure that services are provided in the most cost effective manner
- To assure that only medically necessary care is provided
- To assure that the Medicaid program is operated within legislative appropriation
- To assure that prompt and accurate payments are made to providers
- To assure that accurate Medicaid program and financial information is available for management on a timely basis
- To assure that confidentiality and privacy of client information is maintained at all times
- To promote the appropriate utilization of preventive services

MEDICAID PROGRAM MANAGEMENT:

Vacant **DPHHS Deputy Director** **Medicaid Director** **444-4084**	
Mary Dalton **Administrator** **Health Resources** **444-4458**	Vacant **Administrator** **Disability Services** **444-2590**
Lou Thompson **Administrator** **Addictive & Mental Disorders** **444-3969**	Shirley K. Brown **Administrator** **Child & Family Services** **444-5900**
Kelly Williams **Administrator** **Senior & Long Term Care** **444-4147**	Jeff Buska **Administrator** **Quality Assurance Division** **444-5401**
Hank Hudson **Administrator** **Human & Community Services** **444-5901**	Jane Smilie **Administrator** **Public Health & Safety** **444-4141**

PROGRAM MANAGEMENT RELATIONSHIP TO MEDICAID:

DEPUTY DIRECTOR, STATE MEDICAID DIRECTOR
- oversight of all Medicaid programs for State of Montana

MARY DALTON, ADMINISTRATOR, HEALTH RESOURCES DIVISION
- hospital services (inpatient and outpatient)
- physician and mid-level practitioner services
- managed care PASSPORT Program, Nurse First, Team Care and Disease Management
- mental health services for children
- dental services
- (non-physician) licensed provider services (e.g. optometrist, therapists, audiologist, etc)
- Indian Health Service facilities
- Early Periodic Screening, Diagnosis and Treatment (EPSDT)
- ambulance and transportation services
- pharmacy services
- school-based services
- durable medical equipment

VACANT, ADMINISTRATOR, DISABILITY SERVICES DIVISION
- waivers for persons with Developmental disability
- targeted case management services for persons ages 16+ with Developmental disability
- Montana Development Center (facility for persons with developmental disability)

LOU THOMPSON, ADMINISTRATOR, ADDICTIVE & MENTAL DISORDERS DIVISION
- mental health services for adults
- home & community based waiver for adults with severe and disabling mental illness
- chemical dependency treatment
- inpatient psychiatric hospital services
- inpatient psychiatric nursing home services

SHIRLEY K. BROWN, ADMINISTRATOR, CHIILD & FAMILY SERVICES DIVISION
- targeted case management services for children at risk of abuse and neglect

KELLY WILLIAMS, ADMINISTRATOR, SENIOR & LONG TERM CARE DIVISION
- long term care services in the community
- home & community based waiver for adults and physically disabled individuals
- nursing facility services, including Montana Veteran's Home

HANK HUDSON, ADMINISTRATOR, HUMAN & COMMUNITY SERVICES DIVISION
- Medicaid eligibility

JANE SMILIE, ADMINISTRATOR, PUBLIC HEALTH & SAFETY DIVISION
- targeted case management services for high risk pregnant women
- breast and cervical cancer screening program for low-income women

LAURIE LAMSON, CHIEF OPERATIONS OFFICER
JEFF BUSKA, ADMINISTRATOR, QUALITY ASSURANCE DIVISION
- facility licensing
- fraud and program compliance
- surveillance utilization & review
- third party liability

MEDICAID PROGRAM OVERVIEW:

The Montana Medicaid program is a joint federal-state program that pays for a broad range of medically necessary health care and long-term care services for certain low income populations. The State administers the program in a partnership with the federal Centers for Medicare and Medicaid Services (CMS). The State is responsible for determining eligibility for low-income populations including pregnant women, children, individuals with disabilities and the elderly. The Medicaid benefits package is broad and flexible and may range from preventive services to long-term care. The Montana Medicaid program has flexibility with CMS to: 1) design our own benefits package subject to certain minimum requirements and 2) determine provider reimbursement rates based on approved methodologies.

Medicaid services are funded by a combination of federal and state (and in some situations, local) funds. In Montana, the matching rate is approximately 68% federal and 32% state funds. Simply stated, if DPHHS receives 32 cents in general funds, the 32 cents becomes a Medicaid dollar. Some Medicaid services receive an enhanced federal match rate such as services provided in Indian Health Service Facilities at 100%; for family planning services at 90%; and services through the breast and cervical cancer program at 78%. In addition, administrative costs of the State are matched at 50% and data systems are matched at 75%.

Medicaid benefits are a defining element of an individual's eligibility. Federal law requires that individuals eligible for Medicaid are entitled to the following services unless waived under Section 1115 of the Social Security Act. These are referred to as mandatory services and include:

- Physician & Nurse Practitioner
- Nurse Midwife
- Medical & Surgical Service of a Dentist
- Laboratory and X-ray
- Inpatient Hospital (excluding inpatient services in institutions for mental disease)
- Outpatient Hospital
- Federally Qualified Health Centers
- Rural Health Clinics
- Family Planning
- Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
- Nursing Facility
- Home Health
- Durable Medical Equipment

States may elect to cover other optional services. Montana has chosen to cover a number of cost-effective optional services including, but not limited to, the following:

- Outpatient Drugs
- Dental and Denturist Services
- Comprehensive Mental Health Services
- Ambulance
- Physical & Occupational Therapies and Speech Language Pathology
- Transportation & Per Diem
- Home & Community Based Services
- Eyeglasses & Optometry
- Personal Assistance Services
- Targeted Case Management
- Podiatry

Indian Health Service and Other Tribal Activities:

Indian Health Service (IHS) Facility: The Montana Medicaid Program provides reimbursement for covered medical services to Medicaid-eligible Native Americans who receive those services through an Indian Health Service (IHS) facility or other approved tribal provider. By law, the Medicaid program acts as the "pass through" agency for these services that are funded with 100% federal funds. Medicaid reimburses outpatient IHS services on an all-inclusive, encounter basis and pays for inpatient services using a per diem payment.

Reimbursed expenditures to (IHS) facilities:

State Fiscal Year	Expenditures
2006 (7-1-05---6-30-06)	$29,005,320
2007 (7-1-06---6-30-07)	$29,583,528
2008 (7-1-07---6-30-08)**	$30,412,650

**SFY 2008 figures reflect claims submitted by August 2008. Providers may submit claims 365 days from the date of service and not all claims may have been submitted and paid for SFY 2008.

The Department contracts with the IHS to provide services at the following eleven locations in Montana: Browning, Crow Agency, Harlem, Lodge Grass, Poplar, Hays, Heart Butte, Pryor, Lame Deer, St. Ignatius, and Wolf Point. The facilities at Browning, Crow Agency, and Harlem provide both inpatient and outpatient services. All other facilities provide only outpatient services. The Department also contracts separately for services at the Rocky Boy reservation since they are a self-governing tribal entity. The Indian Health Board of Billings, the Helena Indian Alliance, the Native American Center of Great Falls and the North American Indian Alliance of Butte operate and are paid as Federally Qualified Health Care Center's.

Medicaid Administrative Match (MAM): In December 2006 the Department and CMS hosted a workshop for Montana Tribes on MAM. This began the initial work with the Tribes to develop a program to reimburse Tribes for Medicaid related administrative activities. The Medicaid Administrative Match (MAM) is a federal reimbursement program for the costs of "administrative activities" that directly support efforts to identify, and/or to enroll individuals (similar to schools) in the Medicaid program or to assist those already enrolled in Medicaid to access benefits. Through MAM, contracted Montana Tribes are able to be reimbursed for allowable administrative costs directly related to the Montana State Medicaid plan or waiver service. The Montana Tribal Cost Allocation Plan will give tribes a mechanism to seek reimbursement for the Medicaid administrative activities the Montana Tribes now perform. The program, the first in the country, started July 1, 2008 with five of the seven Tribes indicating interest in participating.

Chippewa-Cree Agreement: In December 2007 the Department executed an agreement with the Chippewa Cree Tribe to facilitate the provision of Medicaid benefits to reservation residents. The agreement enables the Tribe to make Medicaid eligibility determinations on the reservation, reducing barriers or delays that might otherwise impede tribal members from obtaining Medicaid benefits and proper medical care.

Reimburse IHS Facilities for Pharmacy Services through the Department's Prescription Drug Card System (PDCS: Point of Sale) to Obtain 100% FMAP: The Department has been working with IHS to allow the system to accept IHS pharmacy service claims. In order to resolve differences in policies the Department changed its rules to increase the supply of medication for maintenance drugs from a maximum of 34 days to a 90 day supply or, 100 doses whichever is greater. This rule has been approved by CMS and is in the Medicaid state plan. Further changes such as specialized coding may be needed; the Department is ready to assist IHS to resolve these and any other concerns when they are ready to submit claims using the point of sale system.

Encourage and assist Tribes in billing crossover claims for dual eligible individuals by submitting to Medicaid the balance of health claims not paid by Medicare, thus saving IHS funds: The Department encouraged IHS to bill to Medicaid the balance not paid by Medicare on health claims for dual eligible individuals (Medicare and Medicaid). Beginning in early 2008, the IHS working with the Tribes and Department started billing Medicaid for the balance of crossover claims not paid by Medicare. This resulted in the savings of IHS funds.

Reimbursement of Personal Care Attendant Services through IHS: The Department implemented a change in July 2007 to allow this service to be reimbursed at 100%, instead of the Federal Matching Assistance Payment (FMAP) level. With no state funding match required state general fund dollars were saved.

ELIGIBILITY

Although State participation in Medicaid is optional, any State that has Medicaid programs must provide coverage to certain groups or "categories" of people – referred to as categorically eligible. These mandatory groups are described below.

Mandatory Populations:

Families with Dependent Children
Families whose income and resources are below the Family Related Medicaid limits may receive Medicaid. The eligibility for Medicaid is determined separately from TANF.

Pregnant Women
Low-income pregnant women are eligible for Medicaid if their family income is less than 150% of the Federal Poverty Level (FPL) (increased from 133% as of July 1, 2007), and their resources do not exceed $3,000 (chart for 150% of FPL is on the following page).

Children
Medicaid is the largest provider of health coverage for children in the State of Montana. During State Fiscal Year 2007 the average number of children enrolled each month was 45,281. Children are eligible for Medicaid if their family's countable resources do not exceed $15,000 and if the family meets other financial and non-financial criteria. Eligibility differs by age group.

- **Children in Subsidized Adoption or Foster Care**

  Any child eligible for an adoption subsidy through the Department, Child and Family Services Division, is automatically eligible for Medicaid. Any child placed by the Department's Child and Family Services Division into licensed foster care is eligible for Medicaid.

- **Infants and Children through Age 5**

  These children are provided with full coverage under the Medicaid program if family income is less than 133% of the Federal Poverty Level (FPL).

- **Children Ages 6 through 18**

  Children ages 6 through 18 are covered if family income is not greater than 100% FPL. Federal OBRA 89 required states to implement minimum coverage for children ages 6 through 18 at 100% of the FPL.

2007 Federal Poverty Level Gross Monthly Income			
Family Size	100% FPL	133% FPL	150% FPL
1	$851	$1,132	$1,277
2	$1,141	$1,518	$1,711
3	$1,431	$1,903	$2,147
4	$1,721	$2,289	$2,582
5	$2,011	$2,675	$3,017
6	$2,301	$3,060	$3,452
7	$2,591	$3,446	$3,887
8	$2,881	$3,832	$4,322
Over 8 add for each person	$290	$386	$435

Early and Periodic Screening, Diagnostic and Treatment Benefit (EPSDT)
(EPSDT) are required services under the Medicaid program for categorically needy individuals under age 21. The EPSDT benefit is optional for the medically needy population. However, if the EPSDT benefit is elected for the medically needy population, the EPSDT benefit must be made available to all Medicaid eligible individuals under age 21.

A Comprehensive Child Health Program –The EPSDT benefit consists of two, mutually supportive, operational components: 1) assuring the availability and accessibility of required health care resources, and 2) helping Medicaid recipients and their parents or guardians effectively use them.

These components enable Medicaid agencies to manage a comprehensive child health program of prevention and treatment to systematically:

- Seek out eligible individuals and inform them of the benefits of prevention and the health services and assistance available;
- Help them use health resources effectively and efficiently;
- Assess the child's health needs through initial and periodic examinations and evaluation; and
- Assure that health problems found are diagnosed and treated early before they become more complex and their treatment more costly.

States have the flexibility within the Federal statute and regulations to design EPSDT services that meet the health care needs of clients within its jurisdiction (as long as the state stays within the federally established framework, standards and requirements).

Under the EPSDT benefit States must provide for screening, vision, hearing and dental services at specific intervals. The individuals must meet reasonable standards of medical and dental

practice, which is established after consultation with recognized medical and dental organizations involved in child health care. States must also provide for medically necessary screening, vision, hearing and dental services regardless of whether such services coincide with established periodicity schedules for these services. Additionally, the Act requires that any service that States are permitted to cover under Medicaid that is necessary to treat or ameliorate a defect, physical and mental illness, or a condition identified by a screen, must be provided to EPSDT participants regardless of whether the service or item is otherwise included in the State Medicaid plan.

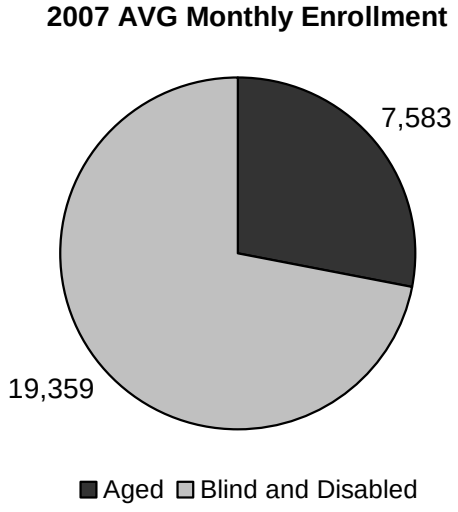
The statute provides an exception to comparability for EPSDT services. Under this exception, the amount, duration and scope of the services provided under EPSDT are not required to be provided to other program eligible individuals or outside of the EPSDT benefit. Services under EPSDT must be sufficient in amount, duration, or scope to reasonably achieve their purpose. The amount, duration, or scope of EPSDT services to clients may not be denied arbitrarily or reduced solely because of the diagnosis, type of illness, or condition. Appropriate limits may be placed on EPSDT services based on medical necessity.

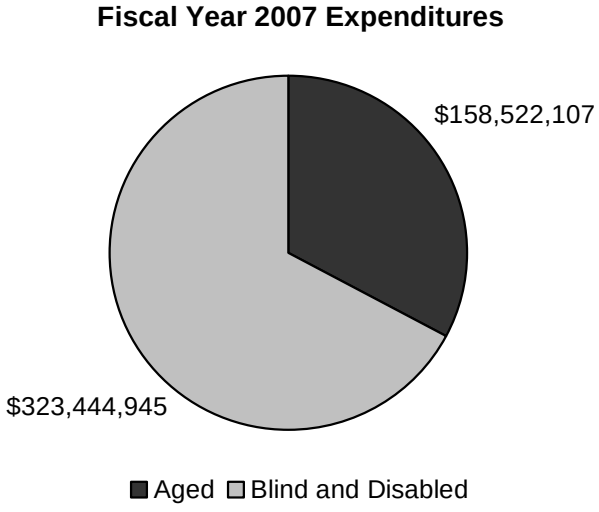
People Who Are Aged, Blind, or Disabled and Receiving Supplemental Security Income (SSI)

Low income aged and disabled persons make up a large group within the Medicaid program. Many aged, blind, and disabled clients live alone and struggle to maintain independence despite health conditions requiring regular medical attention. Medicaid is critical to maintaining their access to medical care and thereby supports a higher level of independence, often reducing the need for more costly medical and support services.

Persons who are aged, blind, or disabled and whose income and resources are below federal Supplemental Security Income (SSI) limits may receive both SSI cash benefits and Medicaid, or they may receive Medicaid only. The Department's Disability Determination Bureau determines disability status for the SSI program. Aged, blind, or disabled persons with income above the SSI standards may be eligible for Medicaid under the medically needy program.

2007		
Family Size	Resource Limit	Monthly SSI Income Limit
1	$2,000	$623
2	$3,000	$934





Optional Populations:

Transitional Medicaid:
Under certain conditions, families are eligible for up to 12 months of extended Medicaid coverage after their eligibility for Section 1931 Medicaid coverage ends due to new or increased earned income. The first six months of this coverage, called Transitional Medicaid, is not dependent on income. To remain eligible in the final six months, the family income must be less than or equal to 185% of the federal poverty level. The family must meet all other eligibility criteria for the entire 12 months.

Family Size	Monthly Income limit-Transitional SFY 2007
1	$1,574
2	$2,111
3	$2,647
4	$3,184
5	$3,720
6	$4,257
7	$4,793
8	$5,330
9	$5,866

Breast or Cervical Cancer
The Montana Legislature passed legislation creating the Montana Breast and Cervical Cancer Treatment group effective July 1, 2001. Low income uninsured women who are screened through the National Breast and Cervical Cancer Early Detection Program and are diagnosed with breast and/or cervical cancer or pre-cancer receive Full Medicaid coverage.

To qualify, the woman must be age 64 or younger, have countable income less than or equal to 200% of the Federal Poverty Level, not be eligible for any other categorically needy Medicaid program, and not have creditable coverage. There is no resource limit for this program.

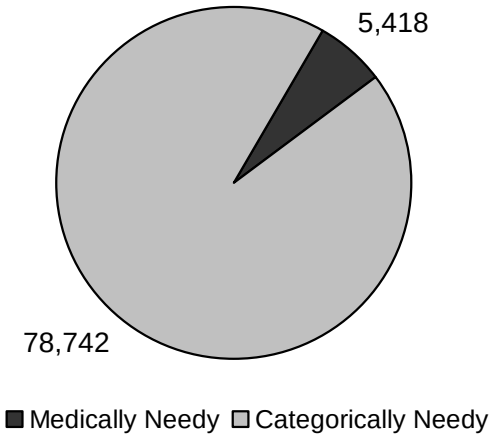
Medically Needy
Medically Needy is a federally matched Medicaid program for persons who are aged, blind, disabled, pregnant or under age 21 and whose resources are less than $2,000 for an individual (or $3,000 for a couple/family) and whose monthly income is more than the relevant categorically needy or income limit. The family-related medically needy program is not tied to the SSI limit. This is a federal optional program that the Montana Legislature has chosen to implement.

Individuals with income above the Categorically Needy program limits are considered Medically Needy. These individuals are responsible each month for their medical bills until they have incurred enough medical expenses, equal to the difference between their countable income and the medically needy income level. Individuals may be Medicaid eligible the first of the month by paying this same amount directly to DPHHS. The individual's "spenddown" amount – the monthly amount the individual must incur before Medicaid coverage applies – is based on income. Medicaid eligibility begins at the end of the spenddown period and continues through the end of the month.

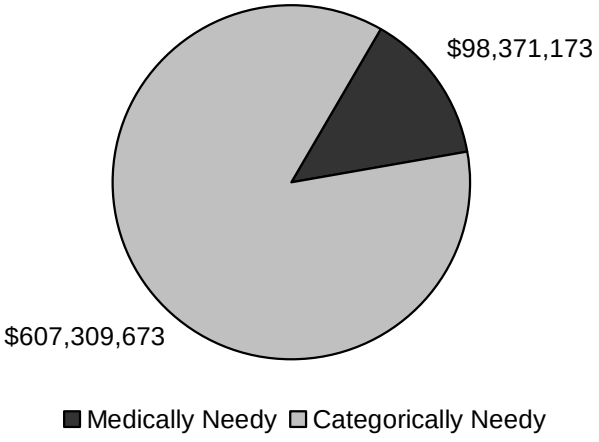
State Fiscal Year 2007 Limits for Medically Needy

Family Size	Resource Limit	Monthly Income Limit
1	$2,000/$3,000**	$525
2	$3,000	$525
3	$3,000	$658
4	$3,000	$792
5	$3,000	$925
6	$3,000	$1,058
7	$3,000	$1,192
8	$3,000	$1,317
9	$3,000	$1,383
10	$3,000	$1,450
**$2,000 for aged, blind, or disabled individuals, $3,000 for children, pregnant women and for aged, blind, or disabled couples.		

2007 AVG Monthly Enrollment



Fiscal Year 2007 Expenditures



STATE FISCAL YEAR 2007 DATA

Summary of Medicaid Enrolled persons for State Fiscal Year 2007 (July 1, 2006 – June 30, 2007)

	Average Monthly Enrollment						
Beneficiary Characteristic	**All**	**Aged**	**Blind & Disabled**	**Adults**	**Children**	**% of Medicaid Total**	**% of Montana Population**
Total	84,160	7,583	19,359	11,937	45,281	100%	
Age							
5 and Younger	21,822	-	640	-	21,182	26%	7%
6 to 19	26,440	-	2,341	-	24,099	31%	19%
20 to 64	27,448	-	15,511	11,937	-	33%	60%
Over 65	8,450	7,583	867	-	-	10%	14%
Gender							
Male	36,724	2,058	9,374	2,545	22,747	44%	50%
Female	47,436	5,525	9,985	9,392	22,534	56%	50%
Race							
White	59,707	6,719	15,890	7,526	29,572	71%	91%
Native American	20,664	716	2,928	3,960	13,060	25%	6%
Other	3,789	148	541	451	2,649	4%	3%
Assistance Status*							
Medically Needy	5,418	3,603	1,472	2	341	6%	
Categorically Needy	78,742	3,980	17,887	11,935	44,940	94%	
Medicare Status							
Part A and B	15,602	7,513	8,051	37	1	19%	
Part A only	93	12	64	17	-	0%	
Part B only	102	21	81	-	-	0%	
None	68,363	37	11,163	11,883	45,280	81%	

* Categorically Needy persons are those eligible for Medicaid services. Individuals with income above the Categorically Needy program limits are considered Medically Needy and responsible each month for their medical bills until they have incurred enough medical expenses equal to the differences between their countable income and the Medically Needy income level.

Note that the figures listed in the table above include (Qualified Medicare Beneficiaries) QMB only recipients. For QMB only recipients, Medicaid pays for Medicare premiums, co-insurance, and deductibles.

As indicated above Medicaid provides services to a disproportionately high percentage of women, children and Native Americans.

Enrollment and Expenditures by County-SFY 2007

County	Population as of July 1, 2007	AVG Medicaid Enrollment	% on Medicaid	Rank by % on Medicaid	Expenditures	AVG Expenditure per Enrollee	Rank by AVG Expenditure per Enrollee
Beaverhead	8,804	706	8%	24	$ 6,380,369	$ 9,037	25
Big Horn	12,798	2,636	21%	3	$ 14,667,906	$ 5,564	52
Blaine	6,550	1,127	17%	5	$ 7,264,357	$ 6,446	47
Broadwater	4,590	324	7%	27	$ 2,430,962	$ 7,503	37
Carbon	9,721	553	6%	40	$ 3,853,167	$ 6,968	42
Carter	1,268	38	3%	56	$ 595,641	$ 15,675	2
Cascade	81,775	7,281	9%	18	$ 61,823,343	$ 8,491	29
Chouteau	5,254	252	5%	46	$ 2,978,379	$ 11,819	9
Custer	11,188	1,200	11%	15	$ 14,179,783	$ 11,816	10
Daniels	1,650	98	6%	37	$ 1,068,892	$ 10,907	12
Dawson	8,558	508	6%	38	$ 6,004,362	$ 11,820	8
Deer Lodge	8,852	1,005	11%	13	$ 11,907,251	$ 11,848	7
Fallon	2,696	126	5%	47	$ 1,872,006	$ 14,857	3
Fergus	11,181	955	9%	21	$ 8,983,236	$ 9,407	22
Flathead	86,844	6,489	7%	25	$ 50,714,375	$ 7,815	35
Gallatin	87,359	2,936	3%	54	$ 21,487,506	$ 7,319	39
Garfield	1,215	62	5%	43	$ 350,292	$ 5,650	50
Glacier	13,382	3,149	24%	2	$ 20,352,894	$ 6,463	46
Golden Valley	1,125	73	6%	30	$ 314,394	$ 4,307	55
Granite	2,852	171	6%	36	$ 1,617,334	$ 9,458	21
Hill	16,568	2,483	15%	6	$ 17,334,610	$ 6,981	40
Jefferson	11,121	606	5%	41	$ 15,049,883	$ 24,835	1
Judith Basin	2,048	125	6%	35	$ 509,384	$ 4,075	56
Lake	28,438	3,738	13%	8	$ 30,369,997	$ 8,125	33
Lewis & Clark	59,998	4,849	8%	23	$ 46,979,370	$ 9,688	18
Liberty	1,796	68	4%	51	$ 693,461	$ 10,198	15
Lincoln	18,885	2,142	11%	14	$ 16,833,533	$ 7,859	34
McCone	1,724	61	4%	53	$ 585,261	$ 9,594	20
Madison	7,426	273	4%	52	$ 2,519,960	$ 9,231	23
Meagher	1,900	129	7%	28	$ 891,373	$ 6,910	43
Mineral	3,895	543	14%	7	$ 3,338,519	$ 6,148	49
Missoula	105,650	8,612	8%	22	$ 71,350,767	$ 8,285	32
Musselshell	4,494	465	10%	16	$ 3,167,260	$ 6,811	44
Park	16,099	926	6%	39	$ 9,938,089	$ 10,732	14

County	Population as of July 1, 2007	AVG Medicaid Enrollment	% on Medicaid	Rank by % on Medicaid	Expenditures	AVG Expenditure per Recipient	Rank by AVG Expenditure per Recipient
Petroleum	438	17	4%	50	$ 86,098	$ 5,065	54
Phillips	3,948	465	12%	10	$ 3,994,482	$ 8,590	28
Pondera	5,943	706	12%	9	$ 5,865,062	$ 8,307	31
Powder River	1,699	73	4%	49	$ 701,173	$ 9,605	19
Powell	7,118	459	6%	32	$ 4,928,044	$ 10,736	13
Prairie	1,044	51	5%	44	$ 654,894	$ 12,841	4
Ravalli	40,396	2,964	7%	26	$ 22,029,003	$ 7,432	38
Richland	9,182	603	7%	29	$ 6,937,377	$ 11,505	11
Roosevelt	10,148	2,996	30%	1	$ 19,059,587	$ 6,362	48
Rosebud	9,182	1,635	18%	4	$ 8,882,072	$ 5,432	53
Sanders	11,033	1,103	10%	17	$ 8,591,747	$ 7,789	36
Sheridan	3,373	218	6%	31	$ 2,733,531	$ 12,539	5
Silver Bow	32,652	3,789	12%	12	$ 33,950,688	$ 8,960	26
Stillwater	8,660	419	5%	45	$ 3,539,817	$ 8,448	30
Sweet Grass	3,807	119	3%	55	$ 1,094,467	$ 9,197	24
Teton	6,023	317	5%	42	$ 3,152,232	$ 9,944	17
Toole	5,144	330	6%	33	$ 2,301,047	$ 6,973	41
Treasure	651	28	4%	48	$ 157,180	$ 5,614	51
Valley	6,899	801	12%	11	$ 8,165,439	$ 10,194	16
Wheatland	1,983	174	9%	19	$ 1,143,814	$ 6,574	45
Wibaux	898	57	6%	34	$ 689,611	$ 12,098	6
Yellowstone	139,936	12,063	9%	20	$ 107,372,263	$ 8,901	27
Other/Institutions		64			$ 1,243,302	$ 19,427	
Montana	**957,861**	**84,160**	**9%**		**$ 705,680,846**	**$ 8,385**	

Population estimates as of July 1, 2007 were sourced from the Census & Economic Information Center, Montana Department of Commerce.

The enrollment and expenditure data excludes CHIP and State Fund Mental Health.

MENTAL HEALTH AND CHEMICAL DEPENDENCY SERVICES

The Addictive and Mental Disorders Division (AMDD) is responsible for the administration of mental health service to adults, while mental health services for children are administered by the Children's Mental Health Bureau within the Health Resources Division (HRD). Both divisions are responsible for planning, operating, coordinating, and ensuring quality in mental health services.

AMDD provided Medicaid funded mental health services to 13,229 adults in SFY 2007; this represents a decrease of approximately 2% from the SFY 2005 caseload. The Children's Mental Health Bureau provided Medicaid funded mental health services to 9,218 children in SFY 2007.

The mental health programs provide a full array of outpatient and inpatient services to adults and youth suffering from mental illnesses through a fee-for-service system with Montana community providers. The community providers deliver services such as therapies, adult foster and group care, day treatment, rehabilitation and support, care coordination and case management services. The program provides inpatient and outpatient hospital services and out-of-home care services including residential treatment, therapeutic foster and group care.

To deliver the variety of services, the program utilizes the services of licensed professional counselors, physicians, hospitals, psychologists, psychiatrists, social workers, mental health centers, mid level practitioners, and out-of-home providers for group care and residential treatment

AMDD's chemical dependency program provides a full array of outpatient and inpatient services to youth, and outpatient services to adults through a fee-for-service system with Montana community providers. Community providers consist of seven inpatient free standing residential treatment providers and 23 outpatient service providers. The community providers deliver services such as assessment, individual and group therapies, family and family group therapies, and case management (liaison services) for youth and adults. Community providers deliver free-standing residential day treatment and free-standing inpatient 24 hour – seven day a week service for youth.

The Meth & Chemical Dependency Expansion project funds two inpatient free standing community based residential facilities and five supportive living facilities for the treatment of addictions. Two of the supportive living facilities will serve eight adults per facility with an average length of stay of six-nine months.

To deliver the variety of services, the program utilizes the services of state-approved substance dependency and abuse treatment programs under contract with the Division's Chemical Dependency Bureau. The primary professional involved in the service delivery within these providers is a licensed addiction counselor. Inpatient and day treatment service requires prior written approval from the Chemical Dependency Bureau as well as continue care reviews.

WAIVERS

General Description: WAIVERS
State Medicaid programs may waive certain requirements, such as statewideness, freedom of choice, or comparability.

- States may *pay for medical care and support services in the home* for persons who would otherwise be eligible (due to the income and resources of a spouse or parent) only in an institutional setting. This is important for families facing institutionalizing a child or family member in order to receive assistance with the medical costs.
- States may *target services to particular groups*, such as elderly individuals, technology-dependent children, individuals with traumatic brain injuries, or persons with mental retardation, developmental disabilities or chronically mentally ill.

Section 1115 waivers of the Social Security Act provides the Secretary of Health and Human Services with broad authority to authorize experimental, pilot, or demonstration project(s) which, in the judgment of the Secretary,(are) likely to assist in promoting the objectives of (the Medicaid statute).

1115 waivers allow flexibility, which is sufficiently broad to allow States to test substantially new ideas of policy merit. States commit to a policy experiment that will be evaluated. Section 1115 should demonstrate something that has not been demonstrated on a widespread basis, the specific research / demonstration findings will be drawn from the projects results.

Section 1915(b) waivers of the Social Security Act provides "the Secretary may . . . waive such requirements of section 1902(other than sections 1902(a) (13)(E) and 1902(a)(10)(A) insofar as it requires provision of care and services described in section 1905(a)(2)(C))."

Section 1915(b) waivers allow States to waive statewideness, comparability of services, and freedom of choice. 1915(b) waivers are limited in that they apply only to existing Medicaid eligible beneficiaries, authority under this waiver cannot be used for eligibility expansions. There are four 1915(b) Freedom of Choice Waivers:
(b)(1) mandates Medicaid enrollment into managed care
(b)(2) utilize a "central broker"
(b)(3) uses cost savings to provide additional services
(b)(4) limits number of providers for services

Section 1915(c) waivers are referred to as the Medicaid Home and Community-Based Services (HCBS) waiver program and are alternatives to providing long-term care in institutional settings. Section 1915(c) of the Act authorizes the Secretary of Health and Human Services to waive

certain Medicaid statutory requirements to enable the state to cover a broad array of home and community-based services as an alternative to institutionalization.

Waivers for Persons with Developmental Disability (DD)

The Developmentally Disabled Waiver (0208.90)----------1915(c):
This waiver was initiated in 1981 (one of the first waivers in the country) to provide community based services to persons receiving services in a small program which had been decertified as an Intermediate Care Facility for Mental Retardation (ICF-MR). This waiver has grown in size and scope during the past 25 years. For the period 7/1/06-6/30/07, Medicaid reimbursed $63,882,230 for 1,993 persons with DD in this waiver. Services consist of supports to 356 children (age 0 through 21) with DD and intensive supports needs and the majority of these children live at home. 1,637 adults received the remainder of the services under this waiver in SFY07.

The vast majority of reimbursement is for group home, supported living, work/day, and transportation services to adults with DD. Other services available under this waiver include the following (which are different in scope, duration or amount from any related state plan services): psychological services, personal care, homemaker, respite, occupational therapy, physical therapy, speech therapy, environmental modifications, nutritional evaluations, private duty nursing, meals and respiratory services. The average cost per person served in this waiver was $32,053 in SFY07 (excluding the cost of any state plan services accessed by the recipient).

Approximately 490 individuals receiving no services are on a waiting list for DD services, while some 878 individuals are receiving some DD services and waiting for other services. In total there are approximately 557 children and 811 adults waiting for DD services.

The "Community Supports" Waiver (0371)----------1915(c):
The Community Supports (CS) waiver was approved by the Centers for Medicare and Medicaid Services in 2001. This waiver served 263 adults (age 18 years and up) with developmental disabilities for the period 7/1/06-6/30/07, expending $1,581,799 in Medicaid funds. The average cost per person was $6,014, thus it is considered a relatively low cost service option. Many persons in the Community Supports waiver live at home, so supports are often purchased to help unpaid primary care givers better meet the needs of an adult family member with DD. Services available in the Community Supports waiver include: homemaker, personal care, respite, residential habilitation, day habilitation, prevocational training, supported employment, environmental modifications, transportation, specialized medical and adaptive equipment, adult companion, private duty nursing, social/leisure/recreation opportunities, health/safety supports and educational services.

Senior Long Term Care (SLTC) Waivers

Home and Community Based Services Waiver-Elderly and Physically Disabled----1915(c):
The Home and Community Based Services (HCBS) waiver program is targeted to Medicaid recipients who have a physical disability and those who are 65 and older. The program recognizes that many individuals at risk of being placed in institutional settings can be cared for in their homes and communities, preserving their independence and ties to family and friends, at a cost no higher than that of institutional care. To qualify a person must be financially eligible for

Medicaid and meet the program's level of care requirements in a nursing facility or hospital. The Department contracts with case management teams to develop an individual plan of care in conjunction with the consumer and the attending physician. Total waiver expenditures may not exceed funds appropriated by the Legislature. Waiver services are individually prescribed and arranged according to the individual need of the consumer. Waiver services include case management, respite, adult residential care, specialized services for those with traumatic brain injuries, environmental modifications, adult day health and personal response systems.

Big Sky Bonanza (BSB) Waiver----------1915(c):
In addition to the HCBS waiver program, the SLTC Division developed a new waiver, called the Big Sky Bonanza (BSB) waiver, which is now available in most counties of the State. The BSB waiver is similar to the HCBS waiver program, but provides more flexibility and choice through increased consumer direction.

Addictive and Mental Disorders Division (AMDD) Waiver

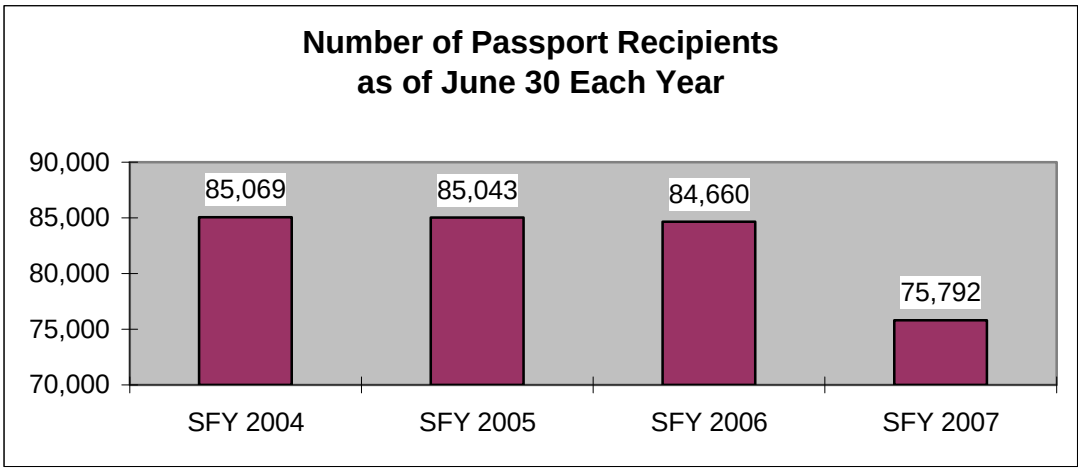
Home and Community Based Services-AMDD----------1915(c):
Montana was a recipient of a 1915(c) Home and Community Based Services Waiver in December 2006. The waiver allows Medicaid reimbursement for community-based services for individuals who are 18 years of age or older with severe disabling mental illness (SDMI) who meet certain criteria for nursing home level of care. The waiver's 125 slots are distributed among three geographic areas in the state. Core sites include Billings, Great Falls, and Butte and surrounding counties for each. In each site, services are coordinated by a team that is made up of a registered nurse and a social worker. Services provided to persons enrolled in the SDMI waiver include case management, Wellness Recovery Action Plan (WRAP), illness management and recovery program, non-medical transportation, specialized medical equipment and supplies, personal emergency response, adult day care, respite, private duty nursing services, day habilitation, prevocational services, supportive employment, additional occupational therapy, adult residential care, habilitation aide, chemical dependency counseling, residential and day habilitation, supportive living, personal assistance and specially trained attendants, and psychosocial rehabilitation.

Medicaid Managed Care----------1915(b) Waiver

PASSPORT To Health (PASSPORT): is Montana's managed health care program. Under PASSPORT, eligible Medicaid enrollees choose a primary care provider (PCP) who manages their health care. Most services must be provided by the PCP or require the PCP's authorization to be reimbursed by Medicaid. The care management provided by the PCP enhances care while reducing costs by minimizing ineffective or inappropriate medical care to Medicaid recipients. PASSPORT has historically cost avoided millions per year in medical costs and improves quality of care. Quality of and access to care is continuously monitored, and is consistently equal to or better than Medicaid-funded care to similar non-PASSPORT clients.

Medicaid covered approximately 110,000 different people during State Fiscal Year 2007. Approximately 75,800 of these people were enrolled in the PASSPORT Program. (The reported decrease in PASSPORT enrollment in SFY 2007 was a result of the transition to a new

enrollment broker during SFY 2007. Medicaid clients eligible for PASSPORT were not being enrolled at the required rate). PASSPORT operates in 55 of 56 Montana counties.



Basic Medicaid Waiver for Able-Bodied Adults----------1115

In 1996 under the authority of an 1115 welfare reform waiver referred to as Families Achieving Independence in Montana (FAIM), Montana implemented a limited Medicaid benefit package of optional services to the same group of adults eligible for Medicaid under Sections 1925 or 1931 of the Social Security Act (the individuals were age 21 to 64, not pregnant and not disabled). The limited Medicaid benefit package was referred to as "Basic Medicaid". The FAIM welfare reform waiver expired on January 31, 2004. A replacement 1115 waiver was approved effective February 1, 2004 continuing basic Medicaid coverage for able-bodied adults ages 21 to 64, who are not disabled or pregnant and who are eligible for Medicaid under Sections 1925 or 1931 of the Social Security Act.

This waiver excludes coverage by Medicaid for certain optional services: audiology and hearing aids, personal assistance services, durable medical equipment, routine eye exams provided by an ophthalmologist or an optometrist, eyeglasses, dental and denturist services. The Department recognizes there may be situations where the excluded services are necessary as in an emergency or medical situation, or if it is essential for employment. Under these defined situations, if the standards and criteria are met, Medicaid may cover the excluded service. Each individual request is evaluated.

Montana Medicaid Covered Services

Services	Categorically Needy– Children	Categorically Needy – Adults	Medically Needy	Family-Related Adults (Basic Medicaid)
Ambulance	Yes	Yes	Yes	Yes
Anesthesia	Yes	Yes	Yes	Yes
Audiology	Yes	Yes	Yes	No*
Targeted Case Management	Yes – if in target group	Yes – if in target group	Yes – if in target group	Yes – if in target group
Chemical Dependency	Yes	Yes	Yes	Yes
Chiropractic	Yes	QMB only	QMB only	No
Clinic Services	Yes	Yes	Yes	Yes
Comprehensive Mental Health Services	Yes	Yes	Yes	Yes
Dental Services	Yes	Yes	Yes	No*
Dentures	Yes	Yes	Yes	No*
Prescription Drugs	Yes	Yes	Yes	Yes
Dialysis	Yes	Yes	Yes	Yes
Durable Medical Equipment	Yes	Yes	Yes	No*
Emergency Rooms	Yes	Yes	Yes	Yes
Eyeglasses/Optician	Yes	Yes	Yes	No*
Family Planning	Yes	Yes	Yes	Yes
Federally Qualified Health	Yes	Yes	Yes	Yes
EPSDT	Yes	No	Children only	No
HCBS Waiver Services	Yes	Yes	Yes	No
Hearing Aids	Yes	Yes	Yes	No*
Home Dialysis Attendant	Yes	Yes	Yes	Yes
Home Health	Yes;P/A	Yes;P/A	Yes;P/A	Yes;P/A
Hospice	Yes	Yes	Yes	Yes
Inpatient Hospital Care	Yes	Yes	Yes	Yes
Indian Health Service Facility	Yes	Yes	Yes	Yes
Mid-Level Practitioners	Yes	Yes	Yes	Yes
Nursing Facility Services	Yes	Yes	Yes	Yes
Nutrition Therapy	Yes	Diabetics only; **	Children only; **	No
Occupational Therapy	Yes	Yes	Yes	Yes
Optometric	Yes	Yes	Yes	No*
Organ Transplant	Yes	Yes;P/A	Yes;P/A	Yes;P/A

Services	Categorically Needy– Children	Categorically Needy – Adults	Medically Needy	Family-Related Adults (Basic Medicaid)
Out of State Medical Services	Yes; P/A	Yes; P/A	Yes; P/A	Yes; P/A
Outpatient Hospital Care	Yes	Yes	Yes	Yes
Respiratory Services	Yes	No; **	Children only; **	No
Pain management	Yes	Yes	Yes	Yes
Personal Assistance	Yes; P/A	Yes; P/A	Yes; P/A	No
Physical Therapy	Yes	Yes	Yes	Yes
Physician Services	Yes	Yes	Yes	Yes
Podiatry	Yes	Yes	Yes	Yes
Private Duty Nursing	Yes	No; **	No; **	No
Rural Health Clinics	Yes	Yes	Yes	Yes
School Medical Services	Yes	No	Children only	No
Speech therapy	Yes	Yes	Yes	Yes
Transportation	Yes; P/A	Yes; P/A	Yes; P/A	Yes; P/A
X-Ray, Lab and Imaging Services	Yes	Yes	Yes	Yes

* Services may be authorized for certain medical conditions, emergency situations or if essential for employment.

****** Home and Community Based Services waiver may include coverage for these services for enrollees.

Medically Needy: See page 12 for eligibility description.

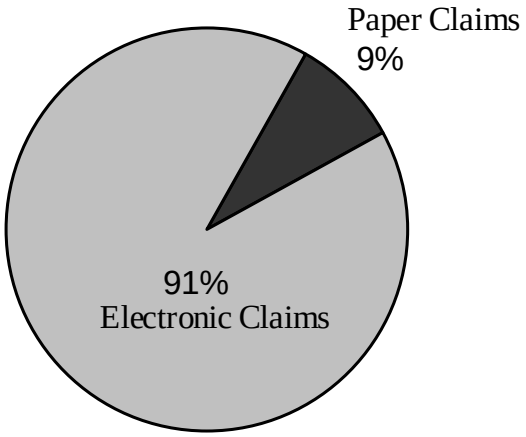
P/A: Prior Authorization is required.

PROVIDERS AND CLAIMS PROCESSING

As of August 31, 2008, there are 10,927 providers enrolled as Montana Medicaid providers. During SFY 2008, 7,849 providers actively billed Montana Medicaid. Providers must submit claims to Affiliated Computer Services (ACS) 365 days from the dates of service for the claims to be considered filed timely.

ACS is contracted with the Department of Public Health and Human Services to serve as the fiscal agent. Below are statistics on the number of claims submitted and processed in SFY 2008.

Claim Type	Number Processed	% of Total
Paper claims	565,402	9%
Electronic claims	5,804,800	91%
Total claims	6,370,202	100%



In State Fiscal Year 2006 there were 6,859,666 claims submitted and processed, of which 844,317 (12%) were paper claims and 6,015,349 (88%) were electronic claims. The percentage of paper claims submitted and processed in SFY 2008 decreased to 9%, with electronic claims submitted and processed increasing to 91%.

In SFY 2008, ACS received 124,365 calls to their call center; 2,755 new providers were enrolled; and 268 providers terminated enrollment.

RATE SETTING PROCESS

The Medicaid Program uses several methods to establish payment rates for services:

Fee-for-Service

Pharmacy Dispensing Fees-Montana Medicaid allows for differential dispensing fees up to $4.94 for pharmacy providers. Dispensing fees are designed to cover a pharmacy provider's cost to dispense a single prescription and are added into the reimbursement formula of each transaction. The maximum dispensing fee of $4.94 is based on the Montana Legislature's most recent biennial appropriation. A provider's dispensing fee is set as follows: In-state providers: up to $4.94 depending on their actual cost to dispense; new and out-of-state providers: $3.50; In-state providers not responding to survey: $2.00. Providers have an opportunity to update their cost to dispense annually through the Department's Dispensing Fee Survey. This survey is sent out yearly to all in-state providers. Dispensing fees are calculated using a formula approved by CMS which uses all costs contributed to the provider's pharmacy operations, divided by their total number of prescriptions filled. This determines the cost to dispense a single prescription. If the cost to dispense is greater than or equal to the maximum allowed, the pharmacy receives the $4.94 dispensing fee. If less, then the pharmacy receives its actual cost to dispense.

Reimbursement Systems

Montana Medicaid's reimbursement systems include a Diagnosis Related Groups (DRG) system for inpatient services for some hospitals, Ambulatory Payment Classification (APC) for these same hospitals for outpatient hospital services, cost based reimbursement for hospitals classified as Critical Access Hospitals and Resource Based Relative Value Scale (RBRVS) for physician/professional services. These reimbursement systems use cost, utilization, and other factors – such as measures of relative value or relative acuity – in determining provider payment rates.

Resource Based Relative Value System (RBRVS)

Montana Medicaid reimburses physicians and other providers who bill on CMS-1500 forms with Medicare's resource based relative value system (RBRVS). Reimbursement is based on the value of a service relative to all other services. The calculations compare the resources needed for a specific service (office expenses, malpractice insurance, and provider work effort and complexity) to those needed for other services. Each service code is assigned one or more relative value units (RVU's) designating its position on the relative value scale. This system was developed nationally by Centers for Medicare & Medicaid Services (CMS), the American Medical Association, and non-physician provider associations; it is adjusted annually. Montana receives the benefit of this large, ongoing investment in research and policy-making without yielding control of costs. The fee for each code is determined by multiplying the RVU by a conversion factor with a dollar value. The conversion factor is Montana-specific to insure the overall budget neutrality of the Medicaid appropriation. The conversion factor is adjusted annually based on the Montana Legislature's most recent biennial appropriation.

Price-Based Reimbursement System

Nursing facilities are reimbursed under a case mix, price-based system where rates are determined annually, effective July 1. Each nursing facility receives a facility specific rate. The statewide price for nursing facility services is established annually through a public process. Each nursing facility's payment is comprised of two components, the operating component including capital and the direct resident care component. Each nursing facility receives the same operating per diem rate, which is 80% of the statewide price. The remaining 20% of the statewide price represents the direct resident care component of the rate and is acuity adjusted. Each facility's direct resident care component rate is specific to the facility based on the acuity of the Medicaid residents served in the facility.

MONTANA PUBLIC HEALTH CARE REDESIGN PROJECT

The 2003 Legislature adopted HJ 13, which requested that the Department undertake a study that would examine the various options available for redesigning the Montana Medicaid program. The Governor appointed a 20-member advisory council to assist the Department in the redesign project (Public Health Care Advisory Council).

In June 2004 the Department completed a Montana Public Health Care Redesign Project Report, in close collaboration with the Public Health Care Advisory Council, and with significant input from the general public. The Report was provided to the 2005 Legislature outlining options that could be undertaken to redesign the health programs administered by the Department. The redesign project was intended to reframe Montana's Medicaid program in a fashion that was financially sustainable into the future.

There were eighteen recommendations resulting from the Redesign Project and they were split into those involving operational changes (actually made and adopted by the Department in advance of June 2004), those involving adjustments or refocusing of existing programs not requiring legislation or changes in funding, and those that required action by the state Legislature and/or the federal government.

The Department adopted seventeen of the recommendations and prepared related legislative and budget requests for presentation to the 2005 Legislative session. In particular the eight recommendations requiring state or federal government action were:

- *Improve Services for Seriously Emotionally Disturbed Children;*
- *Submit a Health Insurance Flexibility and Accountability Waiver (HIFA);*
- *Initiate Changes in Medicaid Eligibility;*
- *Seek Tribal Exemption (from eligibility type changes that could result in a direct shift of costs from the 100 percent federal Medicaid reimbursement to direct costs to either Indian Health Services or tribally sponsored health-care services);*
- *Explore the Implementation of Pharmacy Cost Containment;*
- *Explore the Feasibility of the Submission of a Family-Planning Waiver;*
- *Review the Feasibility of Implementing a Pilot Transportation Brokerage System; and*
- *Seek Codifying Legislation when Considering Changes in Policy or Reduction of Services.*

The status of the progress made of the eight recommendations and any accompanying 2005 Legislation is as follows:

-Improve Services for Seriously Emotionally Disturbed Children
House Bill 183-Authorized the Department to pursue a Medicaid waiver for services to seriously emotionally disturbed children.

A Home and Community Based Services waiver for youth age 6 through 16 with serious emotional disturbance (SED) who, without the waiver services, would be in a psychiatric residential treatment facility (PRTF) was approved by the Centers for Medicare and Medicaid Services (CMS) in November 2007. The PRTF waiver program is not available statewide; it began in Yellowstone County in February, 2008 with capacity to serve up to 20 youth. The PRTF waiver program will move into four other counties within the next five years.

-Submit a Health Insurance Flexibility and Accountability Waiver (HIFA)
Senate Bill 110-Allow the Department to seek a Health Insurance Flexibility and Accountability Waiver (HIFA).

The Health Insurance Flexibility and Accountability (HIFA) waiver was submitted to the Centers for Medicare and Medicaid Services (CMS) in 2006. The HIFA waiver is intended to create a mechanism for Medicaid to pay for services that would provide health-care benefits to low-income uninsured Montanan's at no added cost to the state. In June of 2008 a pared down HIFA waiver was resubmitted to the Centers for Medicare and Medicaid Services for their consideration. The targeted uninsured (those without physical health care coverage) populations to be assisted with Medicaid benefits were refocused to include 1,600 individuals receiving limited mental health benefits through Mental Health Services Plan, 200 youth with a Serious Emotional Disturbance that had aged out of the Montana Foster Care system, and 150 individuals to be assisted with the costs of affordable health care coverage through their ability to participate in the Montana Comprehensive Health Association Premium Assistance Plan.

-Initiate Changes in Medicaid Eligibility
House Bill 552-Revised the asset test used to determine children's eligibility for the Medicaid program by raising the asset limit from $3,000 to $15,000.

This revision in the asset limit was implemented July 1, 2006.

-Seek Tribal Exemption (from eligibility type changes that could result in a direct shift of costs from the 100 percent federal Medicaid reimbursement to direct costs to either Indian Health Services or tribally sponsored health-care services)
House Bill 452-Authorized the Department to pursue a waiver to exempt Indian Health Services providers from Medicaid state plan changes that could reduce reimbursement to tribal service providers.

The Center for Medicare and Medicaid Services (CMS) office was contacted regarding this item and CMS stated to the Department that they cannot change policy for covered services based on race. Should the Department be forced to make reductions in Medicaid services that could potentially affect the Tribes, the Department will notify the Governor's Office and the Tribes prior to the change.

-Explore the Implementation of Pharmacy Cost Containment
Senate Bill 324-Provides for a prescription drug program and prescription drug technical assistance.

During 2005 Montana joined the National Medicaid Pooling Initiative (NMPI) in implementing a Preferred Drug List (PDL). The pooling initiative included seven other states: Nevada, Michigan, Vermont, New Hampshire, Alaska, Minnesota and Hawaii and was implemented through a contract with First Health Services Corporation (FHSC). Under the initiative, the state Medicaid program created a list of preferred medications in 50 classes of drugs. Preferred drugs are chosen based on their clinical efficiency by a committee of Montana physicians and pharmacists and by the Department based on cost savings. By contracting with FHSC, Montana was able to combine our 80,000 covered lives with covered lives of the other NMPI states resulting in over 3,000,000 covered lives which allow our contractor to negotiate lower discounts with Pharmaceutical Manufacturers.

-Explore the Feasibility of the Submission of a Family-Planning Waiver
On July 1, 2008 the Department submitted a Medicaid family planning waiver to the Centers for Medicare and Medicaid Services (CMS) for approval. Upon approval from CMS family planning services are anticipated to be provided to about 4,000 low-income women of child bearing age beginning in July 2009. The waiver will decrease the number of unintended pregnancies, improve the overall health of enrollees, and save money for the Montana Medicaid program.

-Review the Feasibility of Implementing a Pilot Transportation Brokerage System
No action has been taken on this item.

-Seek Codifying Legislation when Considering Changes in Policy or Reduction of Services
Senate Bill 41-Implements guiding principles to be used by the Department when it considers budget reductions or increases. Principles specified included protecting those persons who are most vulnerable and most in need; giving preference to the elimination of an entire Medicaid program or service, rather than sacrifice the quality of care for several programs or services through the dilution of funding; giving priority to retaining those services that protect life, alleviate severe pain and prevent significant disability.

SIGNIFICANT 2007 LEGISLATIVE ACTION RELATED TO MEDICAID PROGRAMS AND THE STATUS OF THOSE ACTIONS

2007 Legislative actions as follows:

Provider Rate Increases-HB 2 increased reimbursement rates for health-care providers in order to improve access to services for Medicaid recipients. Rate increases were approved for implementation in each year (October 1, 2007 and July 1, 2008) of the 2009 Biennium, and have been implemented by the appropriate Division's.

Healthcare for Healthcare Workers-HB 2 allocated funding for the purpose of providing for a provider rate increase for agencies that deliver Medicaid personal assistance and private duty nursing services, when those agencies provide their employees with health insurance coverage that meets a defined criteria. Rate increases will be implemented effective January 1, 2009.

Medicaid Coverage for Pregnant Women-HB 2 increased eligibility requirements from 133 percent to 150 percent of the federal poverty level for pregnant women. The effective date for the increase was July 1, 2007 and the implementation was accomplished.

Medicaid Dental Access-HB 2 raised Medicaid dental provider rates to 85 percent of charges in the aggregate (had been paying 58 percent for adults and 64 percent for children). The effective date for the increase was October 1, 2007 and the implementation was accomplished.

Hospital Utilization Fee-SB 118 continued and raised this daily utilization fee, which allows Medicaid to pay hospitals about 98 percent of their cost of business. The effective date for the increase was effective upon passage and approval and the implementation was accomplished.

Medically Needy Income Disregard-HB 2 authorized a medically needy income disregard to increase the amount of income that is not counted in determining eligibility for people who must "spend down" income to be eligible for Medicaid. The effective date for the increase was October 1, 2007 and the implementation was accomplished.

Medicaid Family Planning Waiver-HB2 approved start-up costs to provide family-planning services to about 4,000 low-income women (with incomes at or below 185 percent of the federal poverty level) of child-bearing age. On July 1, 2008 the Department submitted a Medicaid family planning waiver application to the Centers for Medicare and Medicaid Services (CMS) for approval. Based on receiving approval from CMS the Department anticipates beginning the services in July 2009.

EXPENDITURE ANALYSIS

Medicaid services are funded by a combination of federal and state (and in some situations) local funds. The federal match rate for Medicaid services is based on a formula that takes into account the state average per capita income compared to the national average.

The matching rate for Medicaid administration is set at either 50%, 75% or 90% depending on the type of administrative activities and pre-approval from Centers for Medicare & Medicaid Services (CMS).

Most administrative cost fall into the 50% matching rate, however program activities that are related to medical claims processing, MMIS and certain others can be matched at an enhanced rate of either 75% or 90%. Services provided for family planning also receive an enhanced match rate of 90%.

A decrease in the federal matching rate has a negative effect on the total dollars available for funding services.

Montana Medicaid Benefits Federal Matching

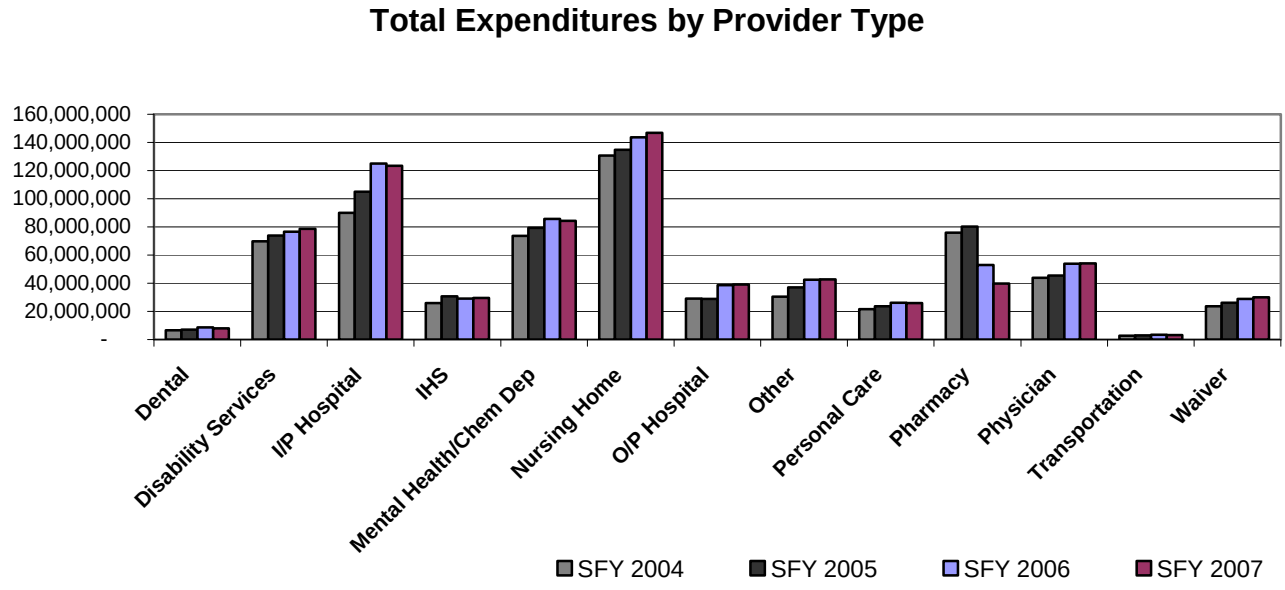
State Fiscal Year	2002	2003*	2004*	2005	2006
Federal Match Rate	72.83%	74.15%	75.36%	71.96%	70.66%
State Funds Percentage	27.17%	25.85%	24.64%	28.04%	29.34%

* Effective April 1, 2003 until June 30, 2004 the Federal matching rate was enhanced by 2.95%.

State Fiscal Year	2007	2008	2009	2010**	2011**
Federal Match Rate	69.29%	68.59%	68.08%	67.49%	67.03%
State Funds Percentage	30.71%	31.41%	31.92%	32.51%	32.97%

** Estimated

SFY 2004 to 2007 EXPENDITURES by Provider Type

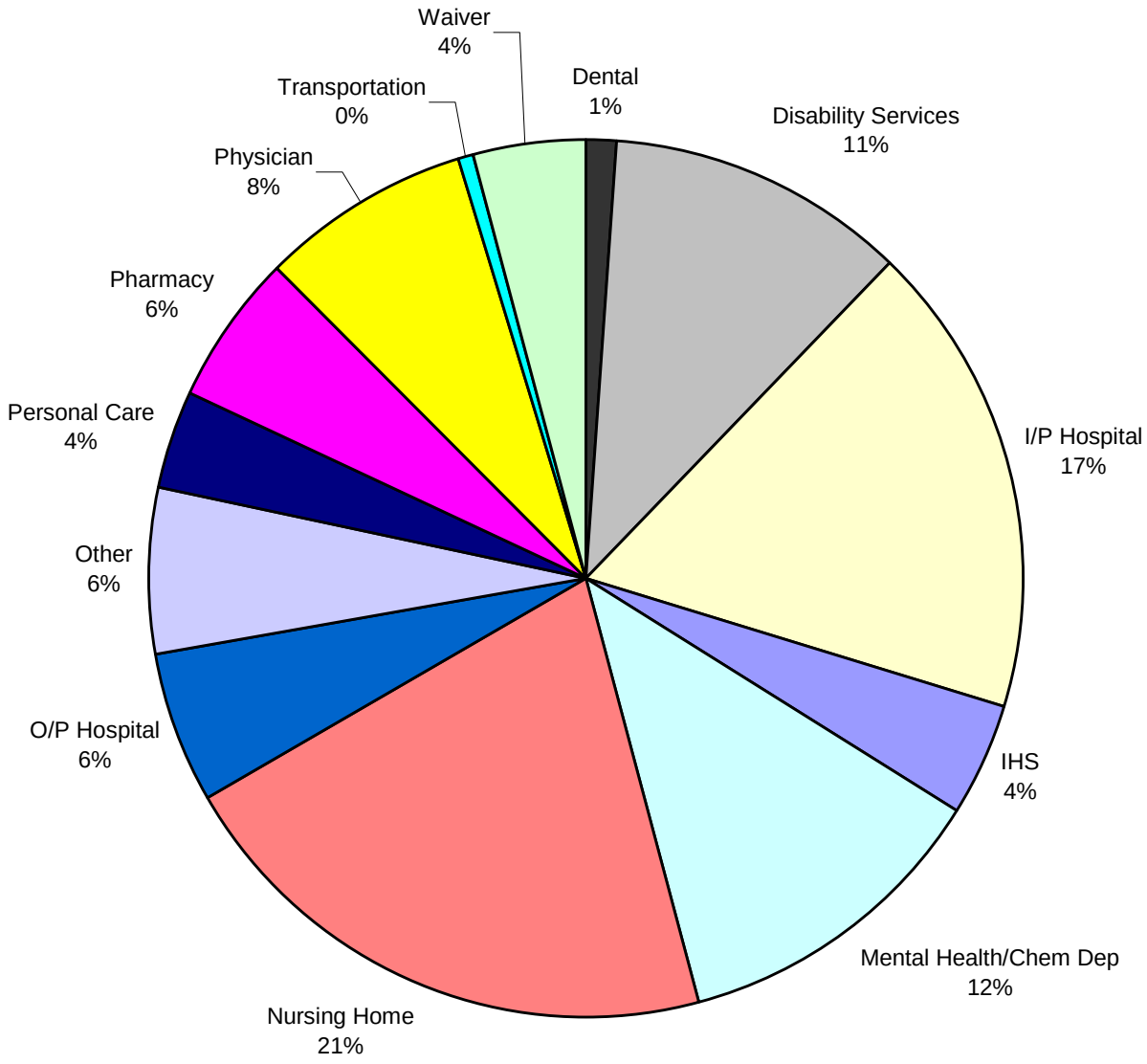


Provider Type	SFY 2004	SFY 2005	SFY 2006	SFY 2007
Dental	$ 6,647,943	$ 6,961,473	$ 8,659,007	$ 7,979,723
Disability Services	$ 69,704,774	$ 73,853,118	$ 76,542,948	$ 78,735,926
I/P Hospital	$ 90,083,563	$ 105,000,577	$ 124,901,450	$ 123,491,098
IHS	$ 25,897,307	$ 30,701,067	$ 29,005,320	$ 29,583,528
Mental Health/Chem Dep	$ 73,561,663	$ 79,208,913	$ 85,612,338	$ 84,372,960
Nursing Home	$ 130,681,000	$ 134,819,641	$ 143,741,963	$ 146,777,719
O/P Hospital	$ 29,159,522	$ 28,885,395	$ 38,578,863	$ 38,987,299
Other	$ 30,443,834	$ 37,078,444	$ 42,431,157	$ 42,692,963
Personal Care	$ 21,636,577	$ 23,551,534	$ 26,153,289	$ 25,851,629
Pharmacy	$ 76,001,604	$ 80,135,704	$ 52,902,909	$ 39,751,123
Physician	$ 43,772,463	$ 45,437,188	$ 53,912,696	$ 54,204,539
Transportation	$ 2,690,425	$ 3,060,819	$ 3,499,143	$ 3,222,126
Waiver	$ 23,651,739	$ 26,047,912	$ 28,765,335	$ 30,030,213
Total	$ 623,932,414	$ 674,741,785	$ 714,706,418	$ 705,680,846

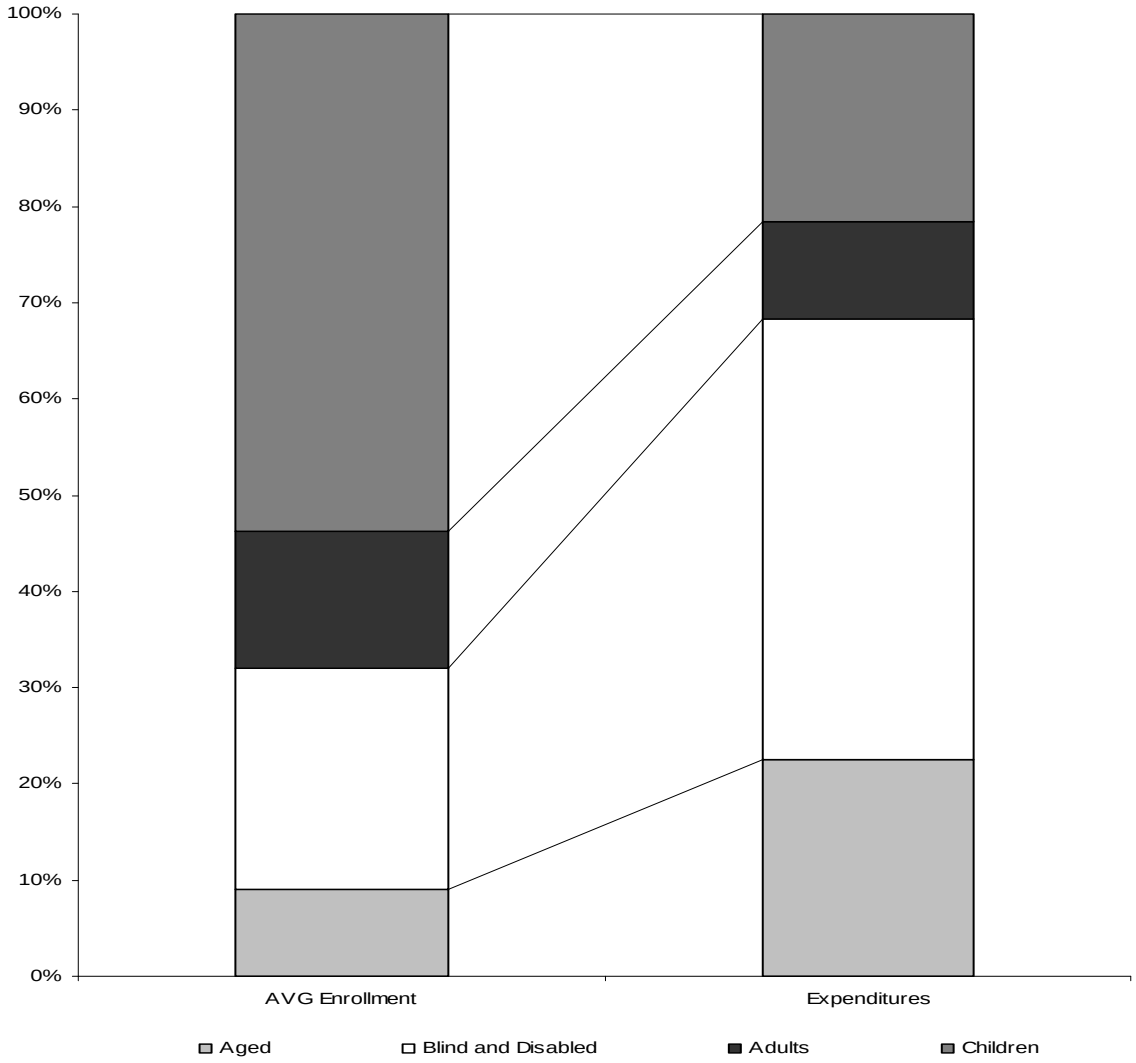
Pharmacy expenditures have been reduced by the amount of rebates collected, and with the 2006 implementation of Medicare Part D. I/P Hospital expenditures include Hospital Utilization Fees and DSH payments. Nursing Home expenditures include IGT payments. (Medicaid Buy-In expenditures are not included).

All expenditures are sourced from those recorded on the Montana Medicaid Management Information System (MMIS) and from those benefit related expenditures paid outside of the MMIS.

SFY 2007 EXPENDITURES by Provider Type



SFY 2007 EXPENDITURES by Major Aid Category

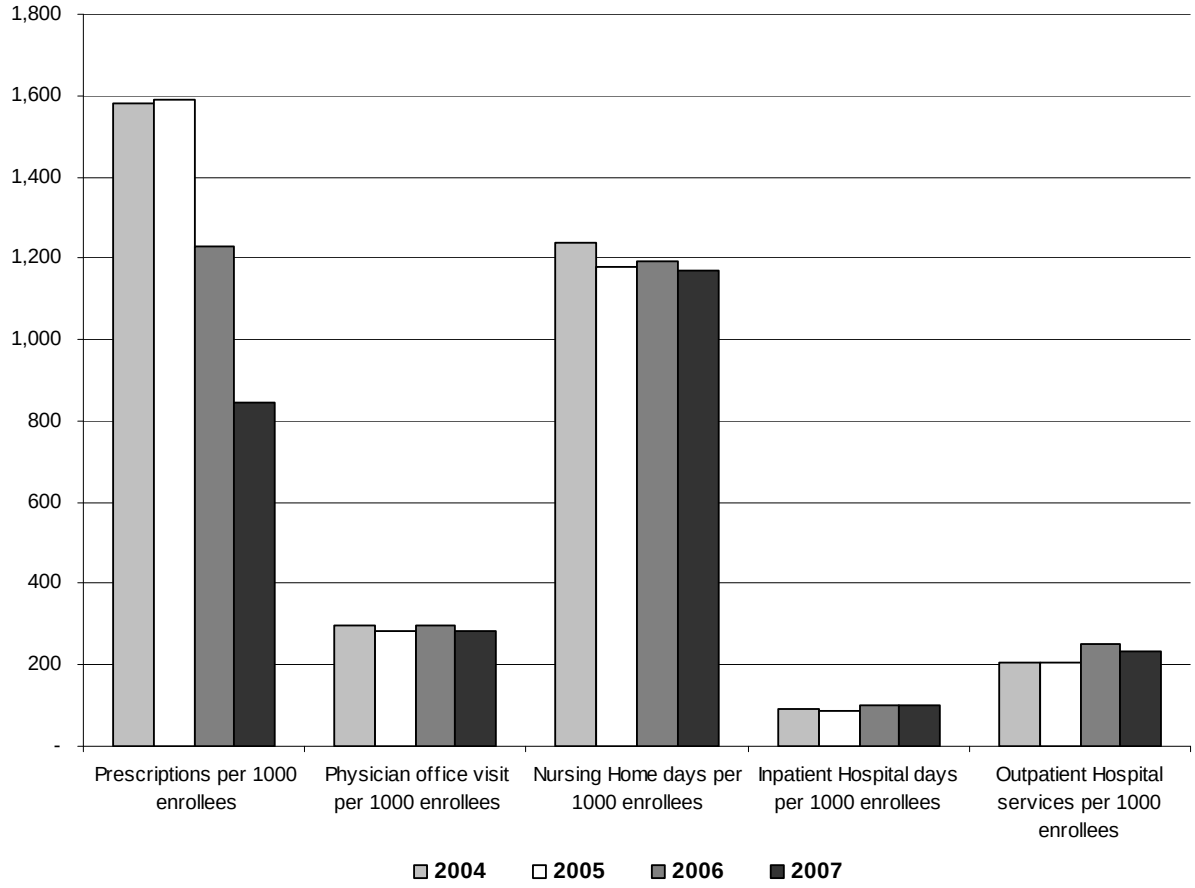


	AVG Enrollment	% of Enrollment		Expenditures	% of Expenditures
Aged	7,583	9%	$	158,522,107	22%
Blind and Disabled	19,359	23%	$	323,444,945	46%
Adults	11,937	14%	$	71,424,882	10%
Children	45,281	54%	$	152,288,912	22%

The chart at the left shows Medicaid enrollment in 2007 by aid category. The chart to the right reflects funds expended by aid category. The Aged and Disabled are a relatively small percentage of the entire Medicaid population, but account for a high percentage of the Medicaid funds expended. Conversely, Children represent slightly more than half of the Medicaid population but account for approximately one-fifth of the cost.

Units of Service

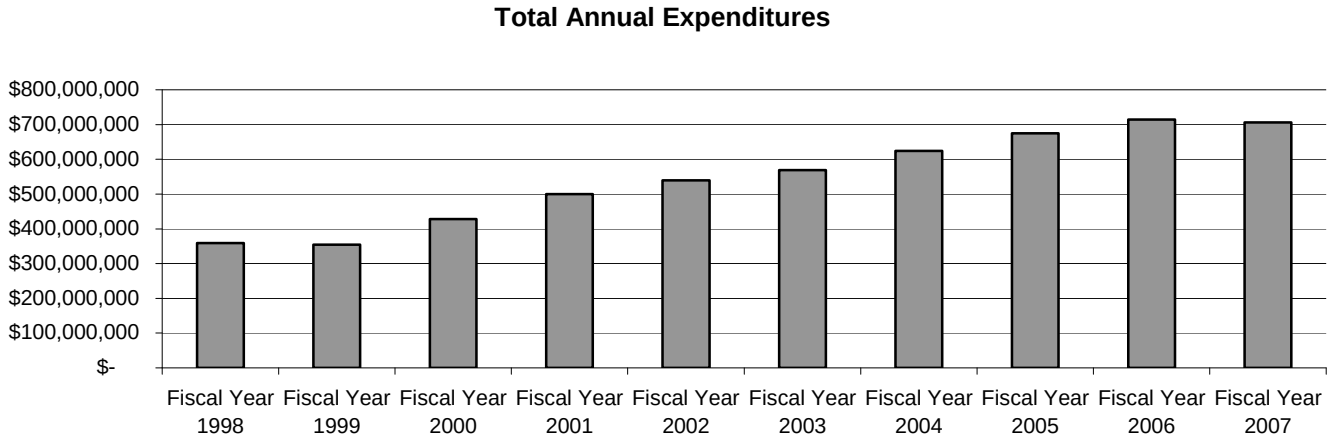
The definition of a unit of service varies greatly both within and between provider types. Medicaid covers approximately 10,000 procedures. These procedures can vary from extreme complexity to procedures as simple as stitching a minor wound. The total units of service is affected each year by a number of factors including patient acuity, technology changes, and changes in treatment protocol.

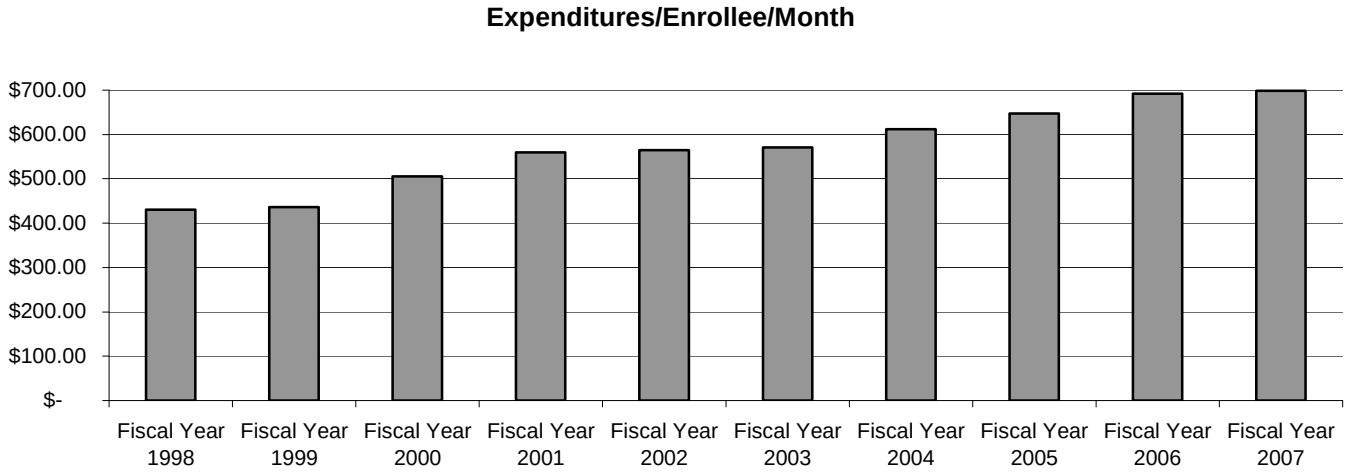


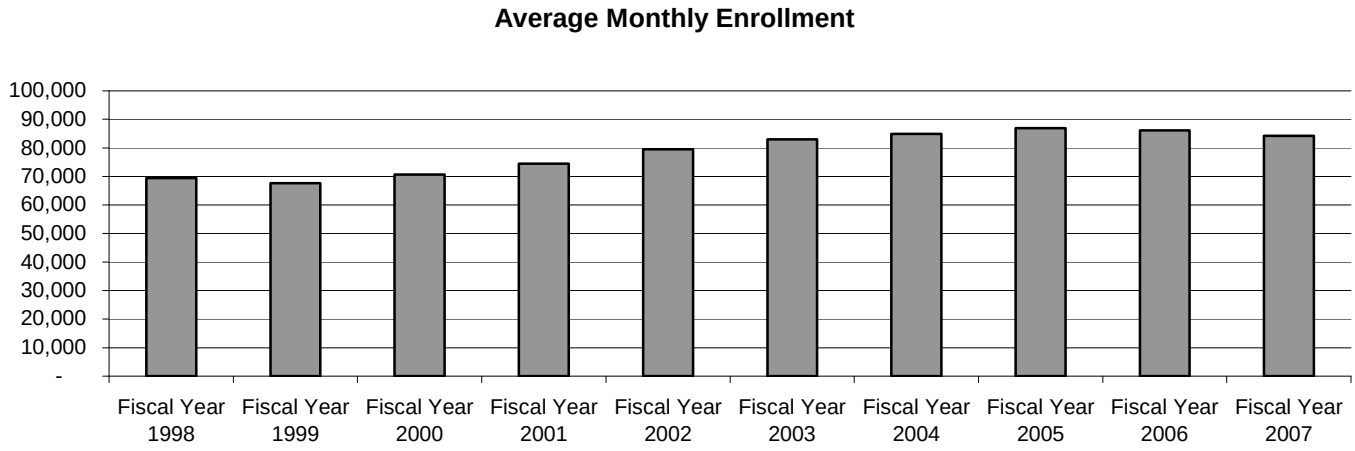
	2004	2005	2006	2007
Prescriptions per 1000 enrollees	1,581	1,589	1,229	845
Physician office visit per 1000 enrollees	297	283	295	283
Nursing Home days per 1000 enrollees	1,239	1,178	1,191	1,168
Inpatient Hospital days per 1000 enrollees	90	89	99	100
Outpatient Hospital services per 1000 enrollees	205	207	251	233

Physician and Hospital services exclude services where Medicare is the primary payor.

10 Year History of Expenditures and Enrollment

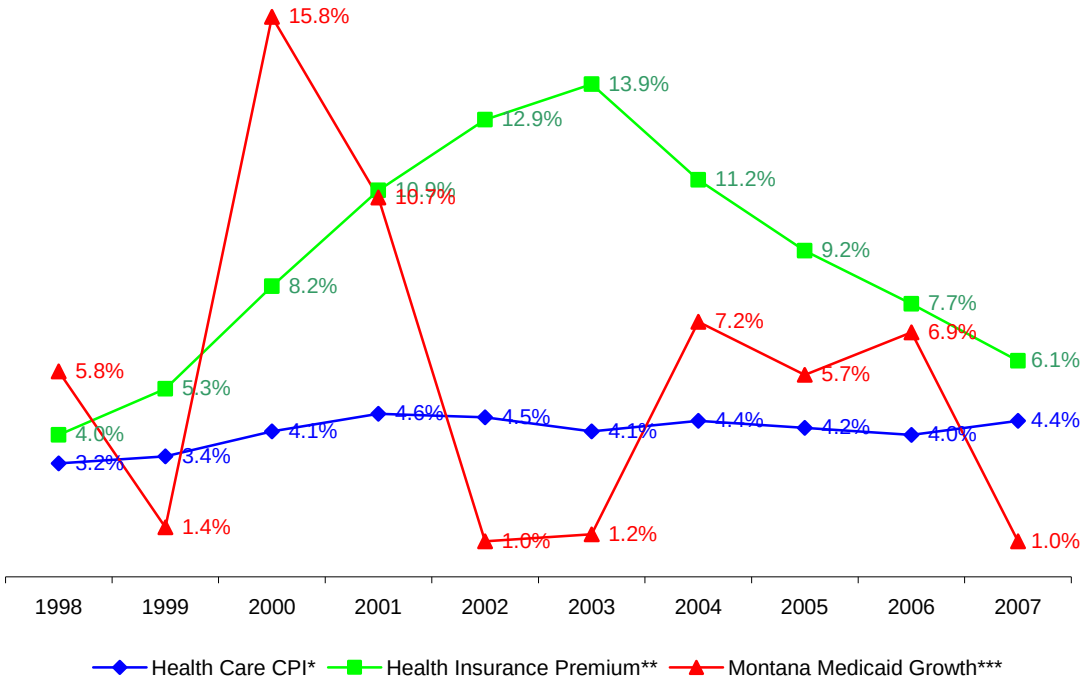






These charts exclude the expenditures and enrollment of CHIP and State Fund Mental Health.

Montana Medicaid Growth Compared to the Health Care Price Index (HCPI) and Increases in Health Insurance Premiums from 1998 to 2007

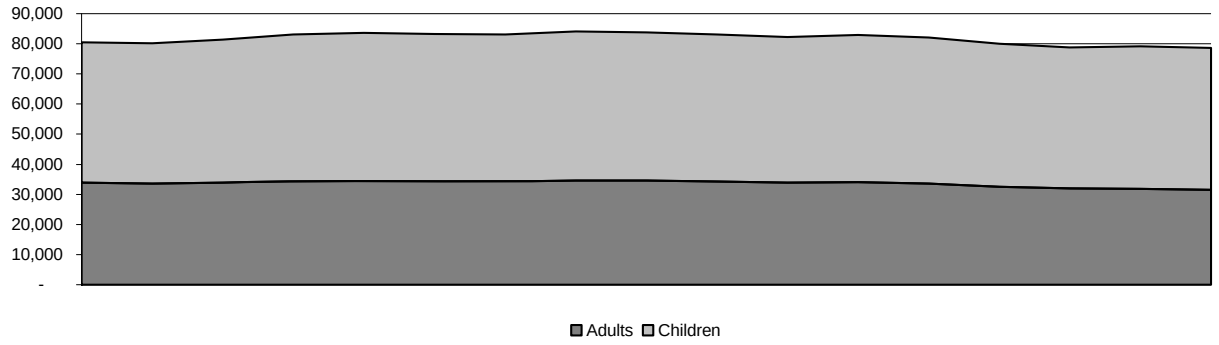


	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
Health Care CPI*	3.2%	3.4%	4.1%	4.6%	4.5%	4.1%	4.4%	4.2%	4.0%	4.4%
Health Insurance Premium**	4.0%	5.3%	8.2%	10.9%	12.9%	13.9%	11.2%	9.2%	7.7%	6.1%
Montana Medicaid Growth***	5.8%	1.4%	15.8%	10.7%	1.0%	1.2%	7.2%	5.7%	6.9%	1.0%

*Health Care CPI from US Department of Labor 1982-1984 base year.
**Health Insurance Premium increases from Kaiser/HRET.
***Montana Medicaid growth is based on the per enrollee per month cost increases from year to year.

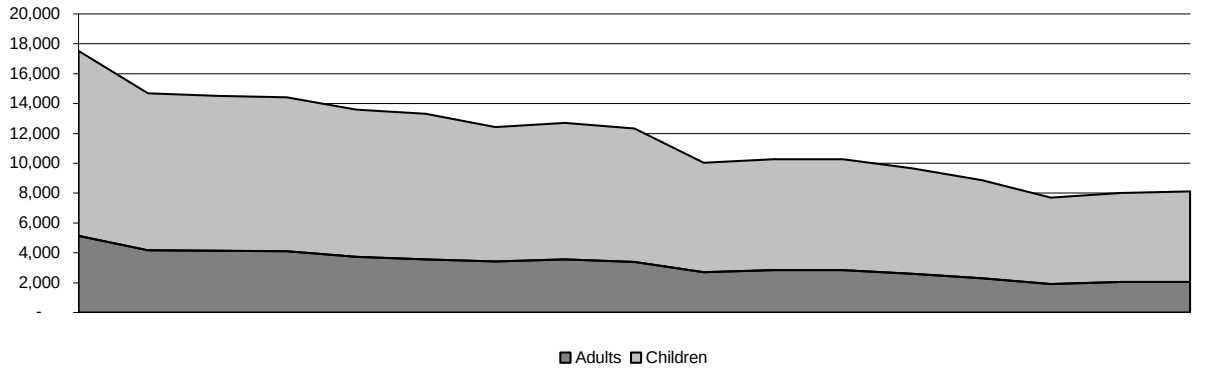
The following historical eligibility charts exclude Qualified Medicare Beneficiaries (QMB) only recipients. For QMB only recipients, Medicaid pays for Medicare premiums, co-insurance, and deductibles. The charts beginning on page 14 show average enrollment for Medicaid and include QMB only recipients because their costs are also shown throughout.

All Medicaid Eligibles, 2003-2007 (Excludes QMB only)



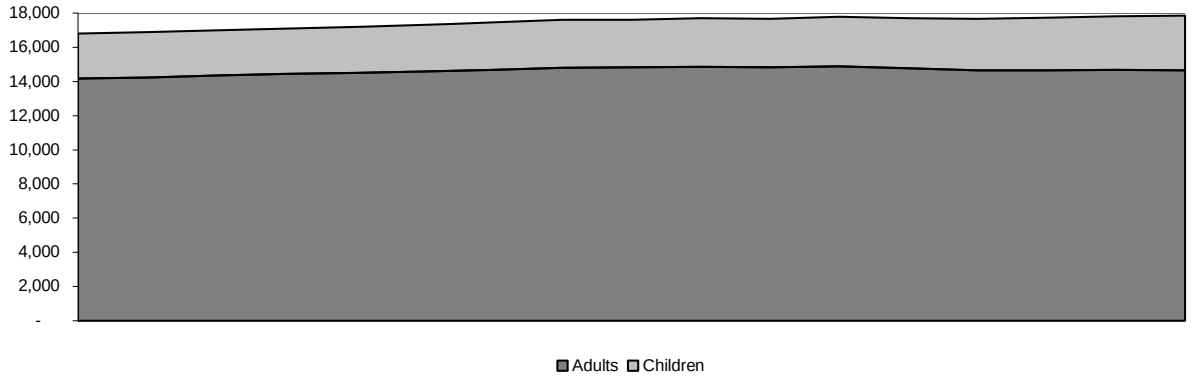
	Jun-03	Sep-03	Dec-03	Mar-04	Jun-04	Sep-04	Dec-04	Mar-05	Jun-05	Sep-05	Dec-05	Mar-06	Jun-06	Sep-06	Dec-06	Mar-07	Jun-07
Total	80,424	80,211	81,466	83,044	83,621	83,286	83,157	84,108	83,858	83,175	82,322	82,952	82,067	79,954	78,875	79,123	78,618
Adults	33,837	33,629	33,970	34,326	34,494	34,395	34,317	34,627	34,508	34,220	33,861	34,108	33,546	32,552	31,922	31,855	31,457
Children	46,676	46,582	47,496	48,718	49,127	48,891	48,840	49,481	49,350	48,955	48,461	48,844	48,521	47,402	46,953	47,268	47,161

TANF/Medicaid Eligibles, 2003-2007 (Excludes QMB only)



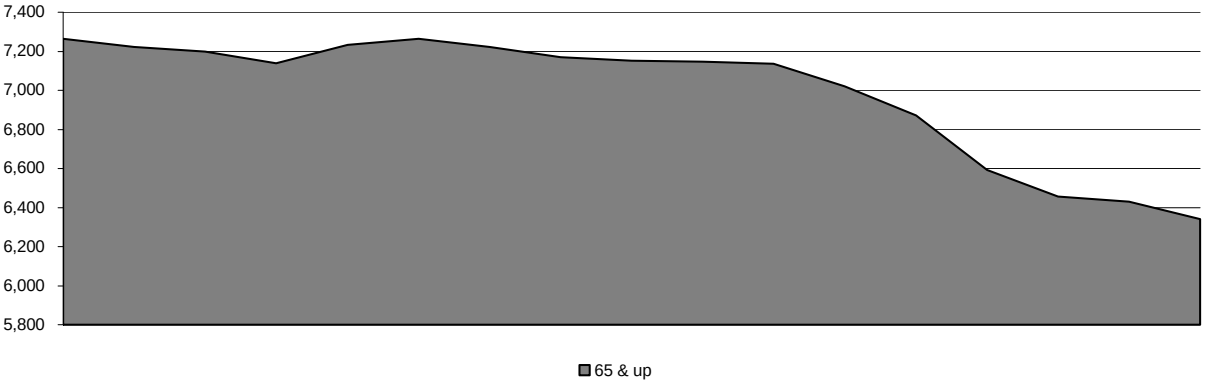
	Jun-03	Sep-03	Dec-03	Mar-04	Jun-04	Sep-04	Dec-04	Mar-05	Jun-05	Sep-05	Dec-05	Mar-06	Jun-06	Sep-06	Dec-06	Mar-07	Jun-07
Total	17,526	14,677	14,513	14,411	13,596	13,337	12,428	12,705	12,328	10,032	10,263	10,278	9,673	8,865	7,692	8,006	8,108
Adults	5,131	4,188	4,153	4,102	3,734	3,572	3,410	3,550	3,399	2,710	2,830	2,848	2,618	2,280	1,928	2,052	2,059
Children	12,395	10,489	10,360	10,309	9,862	9,765	9,018	9,155	8,929	7,322	7,433	7,430	7,055	6,585	5,764	5,954	6,049

Disabled/Medicaid Eligibles, 2003-2007 (Excludes QMB only)



	Jun-03	Sep-03	Dec-03	Mar-04	Jun-04	Sep-04	Dec-04	Mar-05	Jun-05	Sep-05	Dec-05	Mar-06	Jun-06	Sep-06	Dec-06	Mar-07	Jun-07
Total	16,798	16,881	16,987	17,114	17,180	17,322	17,462	17,607	17,607	17,711	17,685	17,803	17,687	17,669	17,733	17,817	17,839
Adults	14,169	14,239	14,354	14,442	14,489	14,600	14,678	14,796	14,821	14,853	14,829	14,882	14,760	14,649	14,652	14,670	14,660
Children	2,629	2,642	2,633	2,672	2,691	2,722	2,784	2,811	2,786	2,858	2,856	2,921	2,927	3,020	3,081	3,147	3,179

Aged/Medicaid Eligibles, 2003-2007 (Excludes QMB only)



	Jun-03	Sep-03	Dec-03	Mar-04	Jun-04	Sep-04	Dec-04	Mar-05	Jun-05	Sep-05	Dec-05	Mar-06	Jun-06	Sep-06	Dec-06	Mar-07	Jun-07
65 & up	7,263	7,222	7,199	7,139	7,233	7,264	7,221	7,170	7,152	7,147	7,135	7,022	6,873	6,591	6,457	6,431	6,341

COST CONTAINMENT

The Medicaid program continues to develop cost containment measures that enhance the cost effectiveness and efficiency of the program. Some examples include:

School Based Services:

- The Office of Public Instruction certifies the match for the general fund portion for Medicaid reimbursed health-related services written into the Children's Individualized Education Plans.

Health Resources Cost Containment Measures:

- Nurse Advice Line - Toll free, confidential advice line available to all people with Medicaid. Registered nurses triage caller's symptoms and guide callers to obtain care in appropriate settings (self-care, physician, or urgent or emergent care).

- Disease Management - Eligible Medicaid clients diagnosed with asthma, diabetes, heart failure, or pain receive individualized counseling and education that empowers them to be more active in managing their health care. Disease Management results in decreased exacerbations and Medicaid expenditures, and improved patient quality of life.

- Team Care - Medicaid clients with a history of using Medicaid services at an amount or frequency that is not medically necessary are required to participate in order to control utilization. Team Care clients are managed by a team consisting of a PASSPORT primary care provider, one pharmacy, the Nurse Advice Line, and DPHHS staff. Team Care currently has 600 clients.

- PASSPORT to Health - Primary Case Management Program was implemented in 1993 to cost-avoid medical costs and improve quality of care. A client chooses one primary care provider who performs or provides referrals for almost all of the client's care. Periodic surveys show that more than 80% of both providers and clients are satisfied with PASSPORT to Health.

- Out-of-State Inpatient & Outpatient Hospital - Prior authorization requiring a mandatory advance approval for all inpatient hospital services out-of-state. Encourage the utilization of available health resources in-state.

Contracts to provide services with:

- Mountain Pacific Quality Health Foundation to assist with transportation services.

- Walman Optical to provide eyeglass services.

- Oregon Health and Science University to participate in the Medicaid Evidence-Based Decisions Project, a collaboration among state Medicaid programs for the purpose of making high quality evidence available to states to support benefit design and coverage decisions.

Pharmacy:

- Prior Authorization - A mandatory advance approval of certain drugs before they are dispensed for any medically accepted indication.

- Drug Utilization Review - Prospective and retrospective review of drug use.

- Over-the-Counter Drug Coverage - When prescribed by a physician a cost effective alternative to higher priced federal legend drugs.

- Mandatory Generic Substitution - Requires pharmacies to dispense the generic form of the drug.

- Other Permissible Restrictions - Minimum or maximum quantities per prescription or number of refills.

- Preferred Drug List and Supplemental Rebates - Medicaid's Drug Utilization Review Board/Formulary committee selects drugs in various classes of medications. Extensive review of the medications by the Board yields drugs that represent the best value to the Medicaid program. Many of the preferred drugs also provide supplemental rebates above what is currently offered to the Medicaid program.

- Drug Rebate Collection - The Department has two full time staff dedicated to the rebate program and the use of the Drug Rebate Analysis and Management System (DRAMS). The staff conducts claims audits and invoice audits prior to invoicing pharmaceutical manufacturers. These staff procedures assure more accurate invoices being sent to the manufacturers and eliminate or reduce disputes with the manufacturers. This results in more timely payments being received from the manufacturers. Drug rebates averaged approximately 30% of the Medicaid pharmacy expenditures. This percentage rate is higher than the past years and is related to Part D and the Average Manufacture Pricing (AMP) calculation. This percentage will be lower as the AMP rates are now being readjusted at the federal level for future fiscal years. The Department has also contracted with Affiliated Computer Services (ACS) to collect rebates on selected physician administered drugs.

Senior and Long Term Care Cost Containment Measures:

- Effective in February of 2006 the look-back period for transferring assets for less than fair market value in order to qualify for nursing home care was extended from three years to five years with transfer penalties starting when the individual is in a nursing home, applies for Medicaid and is otherwise eligible for Medicaid, rather than the month of the asset transfer.

- Beginning in July of 2000 instituted a standardized prior authorization for personal assistance services process, which stabilized growth and reduced expenditures.

- Beginning in January of 2001 the SLTC program utilized additional funds in the form of an intergovernmental fund transfer for counties to provide additional payments to at risk nursing facilities. The federal government is in the process of putting restrictions on the uses of this program, which may reduce or eliminate this funding source in the future.

- Effective July 1, 2001 a new price based reimbursement methodology was adopted for reimbursement of nursing facilities in the state and continues to this day to provide for predictability in reimbursement for these providers.

CHRONOLOGY OF MAJOR EVENTS IN MONTANA MEDICAID

2008 - The Medicaid Administrative Match (MAM) is a federal reimbursement program for the costs of "administrative activities" that directly support efforts to identify, and/or to enroll individuals in the Medicaid program or to assist those already enrolled in Medicaid to access benefits. Through MAM, contracted Montana Tribes are able to be reimbursed for allowable administrative costs directly related to the Montana State Medicaid plan or waiver service. The Montana Tribal MAM Cost Allocation Plan will give tribes a mechanism to seek reimbursement for the Medicaid administrative activities the Montana tribes now perform. Currently the Department is working on finalizing contracts with the Tribes.

2008 - The Hospital & Clinic program implemented the APR-DRG payment system and changed the ACS pricing methodology. On October 1, 2008, Montana Medicaid implemented a new inpatient reimbursement methodology for all hospitals, which is based on "All Patient Refined Diagnosis Related Groups" (APR-DRGs). In-state critical access hospitals will continue to be paid percent of charges using their cost-to-charge ratio. All other hospitals will be paid a prospective APR-DRG payment that reflects the cost of hospital resources used to treat similar cases.

2008 - On July 1, 2008 the Department submitted a Medicaid family planning waiver to the Centers for Medicare and Medicaid Services (CMS) for approval. Upon approval from CMS family planning services are anticipated to be provided to about 4,000 low-income women of child bearing age beginning in July 2009. The waiver will decrease the number of unintended pregnancies, improve the overall health of enrollees, and save money for the Montana Medicaid program.

2008 - In June of 2008 a pared down Health Insurance Flexibility and Accountability (HIFA) waiver was resubmitted to the Centers for Medicare and Medicaid Services for their consideration. The targeted uninsured (those without physical health care coverage) populations to be assisted with Medicaid benefits were refocused to include 1,600 individuals receiving limited mental health benefits through Mental Health Services Plan, 200 youth with a Serious Emotional Disturbance that had aged out of the Montana Foster Care system, and 150 individuals to be assisted with the costs of affordable health care coverage through their ability to participate in the Montana Comprehensive Health Association Premium Assistance Plan.

2008 - Increased the base wage rates for direct-care staff providing services to consumers with developmental disabilities and raised direct-care wages to at least $9.50 an hour.

2008 - The 2007 Legislature increased direct care worker wage to a minimum of $8.50 per hour, but in addition in SLTCD community based services was raised to $9.35 per hour and nursing homes to $9.20 per hour for certified nurse aides and personal care attendants. Also, direct care wage adjustments were legislatively approved for the providers who contract with the Children Mental Health Bureau.

2007 - Nursing facility provider tax was increased by $1.25 from $7.05 to $8.30 per day to fund nursing facility rates and services.

2007 - The eligibility requirements for pregnant women increased from 133% to 150% of the federal poverty level by legislative action.

2007 - The 2007 Legislature increased health-care provider rates, the increases vary across services and provider types, from a low of 1.39% to a high of 4.26%. The increases for SFY2007 generally began in October 2007 and the SFY2008 increases generally began in July 2008.

2007 - Home and Community-Based Services (HCBS) waiver for adults age 18 and over with severe disabling mental illness (SDMI), who without the waiver would be in nursing homes, was implemented. The SDMI waiver is available in certain core areas of the state and the surrounding counties. The waiver team in each core area consists of a nurse and a social worker who coordinates services provided to the covered individuals.

2007-Executed an agreement with the Chippewa Cree Tribe to facilitate the provision of Medicaid benefits to reservation residents. The agreement enables the Tribe to make Medicaid eligibility determinations on the reservation, reducing barriers or delays that might otherwise impede tribal members from obtaining Medicaid benefits and proper medical care.

2006 - Medicare Modernization Act implemented the Medicare Part D drug program that applied to approximately 16,000 Montanans who were eligible for both Medicare and Medicaid (dual eligibles). With the implementation of the Act, the dual eligibles will no longer receive prescription drug coverage through Medicaid, instead their prescription drugs are covered by a Medicare Part D plan**.** The Department is mandated to pay a portion of the drug cost through a Phased-Down Contribution (clawback) for dual eligible clients enrolled in Medicare Part D. Medicaid continues to cover barbiturates, benzodiazepines, smoking cessation drugs, prescription vitamins and the over-the-counter drugs for the dual eligibles as allowed in the Medicaid program.

2006 - The amount of assets a family can have and still qualify for children's Medicaid increased from $3,000 to $15,000 as a result of 2005 Montana Legislative action. Families must continue to meet income requirements to be eligible for children's Medicaid.

2006 - The most recent amendment to the Developmentally Disabled Waiver occurred. The waiver serves people with significant support needs and the amendment expanded service options to include adult foster support, community transition services, adult companionship, assisted living and residential training support.

2006 – The Health Insurance Flexibility and Accountability (HIFA) waiver was submitted to the Centers for Medicare and Medicaid Services (CMS). The Waiver is intended to create a mechanism for Medicaid to pay for services that have historically been funded entirely with state dollars. This will allow the freed up state dollars to leverage additional Medicaid federal dollars.

2006 – The Deficit Reduction Act of 2005 (DRA) mandated certain Medicaid eligibility changes for people who are going to be institutionalized, reside in a nursing home or who are on a waiting list for a Waiver opening. The DRA eligibility changes include increasing the penalty look-back period from three years to five years for nursing home benefits for individuals who transfer assets at less than fair market value, with the look-back period changed to begin when the individual becomes eligible for Medicaid; new citizenship and identity verification requirements of applications for Medicaid; annuities owned by an ineligible or community spouse are considered countable resources for Medicaid applicants; the unpaid balance of a promissory note is considered a countable resource for Medicaid applicants; and the establishment of a $500,000 home equity exclusion limit for long term care applicants/recipients.

2006 – Direct care worker wage increase of $1.00 per hour for nursing facilities and community service providers were implemented utilizing I-149 funding. Also, direct care wage adjustments were legislatively approved for the providers who contract with the Children Mental Health Bureau.

2006 – Implemented a 3% provider rate increase to nursing facilities and community service providers utilizing I-149 funding.

2006 – Nursing facility provider tax was increased by $1.75 from $5.30 to $7.05 to fund nursing facility provider rates and services.

2005 - As a result of the Montana Health Care Redesign Project the 2005 Montana Legislature authorized DPHHS to revise the asset test used to determine children's eligibility for Medicaid and the submission of a Health Insurance Flexibility and Accountability (HIFA) Waiver.

2005 - Montana joined the National Medicaid Pooling Initiative (NMPI) in implementing a Preferred Drug List (PDL). The pooling initiative included seven other states: Nevada, Michigan, Vermont, New Hampshire, Alaska, Minnesota and Hawaii and will be implemented through a contract with First Health Services Corporation (FHSC). Under the initiative, the state Medicaid program will create a list of preferred medications in 50 classes of drugs. Preferred drugs are chosen based on their clinical efficiency by a committee of Montana physicians and pharmacists and by the Department based on cost savings. By contracting with FHSC, Montana was able to combine our 80,000 covered lives with covered lives of the other NMPI states resulting in over 3,000,000 covered lives which allow our contractor to negotiate lower discounts with Pharmaceutical Manufacturers.

2005 - The first five year renewal of the Developmental Disabilities Community Supports Waiver occurred. The waiver offers a number of innovative and flexible service options for persons with limited support needs.

2005 - Hurricane survivors who came to Montana after being displaced could apply for access to Medicaid benefits. In cooperation with the federal government, flexibility was provided in meeting the eligibility requirements they normally would have had to meet to apply for and receive benefits.

2005 – Nursing facility provider tax was increased from $4.50 to $5.30 to fund nursing facility provider rates.

2004 - Team Care program was implemented to targeted to people who over-use the Medicaid system. The program requires a group of identified Medicaid clients to enroll in the program and choose one primary care provider and one pharmacy to manage their health care. Clients will receive the professional care they need and have a team to help them decide how and when to access care.

2004 - Montana Health Care Redesign Project Report was published. The Project resulted from 2003 Montana Legislative action and was intended to examine the various options for redesigning the Montana Medicaid program. The Report was provided to the 2005 Legislature outlining the options that could be undertaken to redesign the identified health programs in a fashion that was financially sustainable into the future.

2004 – Nurse First Care Management program was implemented to reduce ineffective use of medical services. Key components are a Nurse Advice Line for most individuals on Medicaid and a Disease Management program for those with chronic conditions such as asthma, diabetes and congestive heart failure.

2004 – FAIM Basic Medicaid waiver expired on January 31, 2004. A replacement 1115 waiver was approved effective February 1, 2004 continuing basic Medicaid coverage for able-bodied adults ages 21 - 64 who are not disabled or pregnant and who are eligible for Medicaid under - Sections 1925 or 1931 of the Social Security Act.

2004 - Hospital tax was implemented. This change provided increased reimbursement to hospitals using a state tax on hospitals matched with federal Medicaid dollars.

2004 – Nursing facility provider tax increased from $2.80 to $4.50 to fund nursing facility provider rates.

2003 – Children's Mental Health Bureau was created in the Health Resources Division.

2003 – Eliminated coverage of gastric bypass surgery and routine circumcisions at the recommendation of the Medicaid Coverage Review Panel composed of Montana physicians.

2003 – Child and Family Services Division began billing Medicaid for targeted case management services provided to children at risk of abuse and neglect.

2003 – Outpatient reimbursement methodology was changed to Ambulatory Payment Classification (APC).

2003 – On January 10, 2003 implemented a 7% net pay reduction to providers (sunset June 30, 2003).

2003 – On February 1, 2003 reduced inpatient base rate for hospitals reimbursed by DRG prospective payment system (sunset June 30, 2003).

2003 – On August 1, 2003, reduced inpatient base rate for hospitals reimbursed by DRG prospective payment system. Changed all interim reimbursement rates for cost-based facilities to the hospital specific cost to charge ratio.

2002 – Increase cost sharing requirements for which the Medicaid eligible persons are responsible.

2002 – Began covering outpatient chemical dependency for adults.

2002 – Implemented a 2.6% net pay reduction to providers (sunset June 30, 2002).

2002 – Implemented reimbursement reductions to hospital inpatient services by reducing the base rates, decreasing the DRG weights by 2%, and eliminating the additional catastrophic case payment.

2002 – July 1, 2001 moved to a case mix price-based system of reimbursement for nursing facility providers.

2001 – Implemented a mandatory generic substitutive policy for pharmaceuticals in the outpatient drug program.

2001 - The Montana Legislature passed legislation creating the Montana Breast and Cervical Cancer Treatment program for low income uninsured women with breast or cervical cancer diagnosed through the National Breast and Cervical Cancer Early Detection Program, for their cancer treatment.

2001 – Implemented new reimbursement methodology for Ambulance & Dental Services. Included an 18% increase in funding for the dental program.

2000 – Medicaid HMO program was discontinued due to low penetration and high administrative expenses.

2000 – Nursing Facility Intergovernmental Transfers are implemented to save state general fund.

2000 – Hospital Intergovernmental Transfers are implemented.

2000 – Prior Authorization was required in Personal Assistance Services.

1999 – Mental Health Managed Care abandoned per legislative requirement.

1999 - Ambulatory Surgical Center provider reimbursement was restructured to align with Medicare reimbursement methodologies.

1998 – Area Agencies on Aging converted state general fund to buy slots to expand Waiver.

1997 - New MMIS contract was instituted with Consultec as the fiscal agent (Consultec later changed its name to Affiliated Computer Services – ACS).

1997 – Resource Based Relative Value System (RBRVS) was implemented to reimburse Physicians, Mid-Level Practitioners and Therapies.

1997 - Mental Health Managed Care was implemented. This program institutes a full-risk, capitated managed care contract for all mental health services statewide.

1997 – Prior authorization was required of Home Health Agency services.

1996 – Federal welfare reform was passed on August 22, 1996. Under the Personal Responsibility and Work Opportunities Reconciliation Act, Medicaid was "de-linked" from AFDC/TANF and began operating without regard to eligibility for cash assistance.

1996 - Departmental reorganization was implemented. Reorganization results in a decentralization of Medicaid; services are managed in divisions primarily responsible for services to specific populations. For example, the Addictive and Mental Disorders Division manages all Medicaid mental health services.

1996 - New outpatient prospective payment system was introduced. The system uses Day Procedure Groups (DPGs) to bundle services at one basic rate.

1995 - Liens and Estates Recovery Program was implemented by the legislature.

1995 - The Families Achieving Independence in Montana (FAIM), welfare reform waiver, received federal approval. The FAIM program began phasing-in implementation in February 1996. Even though the cash assistance caseload experienced a significant reduction, Medicaid eligibility continued for most of families. Cost savings were due to the reduced package of services under FAIM Basic Medicaid, not because of decreased caseloads.

1995 - The Medicaid HMO program was implemented for AFDC recipients in counties where HMOs exist.

1993 - Passport to Health program was implemented. The program assigns a primary care case manager provider to each participating Medicaid enrollee as a health care manager and gatekeeper of services. The program has yielded significant savings in subsequent years and maintained quality of care.

1993 - New hospital reimbursement system was implemented. The system features updated DRG rates and restrictions on procedures outside of the basic reimbursement package. This change results in significant savings in subsequent years.

1993 - Out of state hospital initiative was implemented. This program restricts the use of higher cost out of state hospitals when in state hospitals provide the same services. This initiative results in significant savings in subsequent years.

1993 - Medicaid coverage for inpatient psychiatric services was terminated by the legislature

1992 - Federal OBRA 89 increased eligibility for pregnant women and children under age 6 to 133% of the federal poverty level. OBRA 89 stipulates that children are eligible for all medically necessary services.

1992 - Federal OBRA 90 was implemented. A major component of this mandate is to increase eligibility for children aged 6 through 18 to 100% of the federal poverty level. This mandate is being phased in through 2002.

1992 - "Residential Psychiatric Services" was implemented as a Medicaid Service. This service brings rapid increases in cost for the next several years.

1992 - Drug Rebate Program was implemented and began to return a significant portion of prescription drug costs to the state in the form of rebates.

1992 - Formulary and Drug Utilization Review Program was implemented for Medicaid pharmacy services. This program provides significant internal controls and cost savings in subsequent years.

1991 - Nursing home provider tax was implemented. This change increased reimbursement to nursing homes using a state tax on nursing homes matched with federal Medicaid dollars.

1990 - Federal OBRA 87 was implemented. This federal mandate imposed new regulations for nurse aides, client safety, and client screening. This mandate affects primarily the nursing home industry and increased Medicaid costs through increased reimbursement to providers. OBRA87 also raised the threshold for financial eligibility to 100% of poverty for pregnant women and children younger than 6 years.

1988 - "Inpatient Psychiatric Services for Children under age 21" became a Medicaid service. This service increased costs rapidly for the next several years.

1987 - New Hospital reimbursement system was instituted. This Diagnosis Related Group (DRG) system is a prospective rate system.

1985 - New MMIS was instituted with Consultec as the fiscal agent.

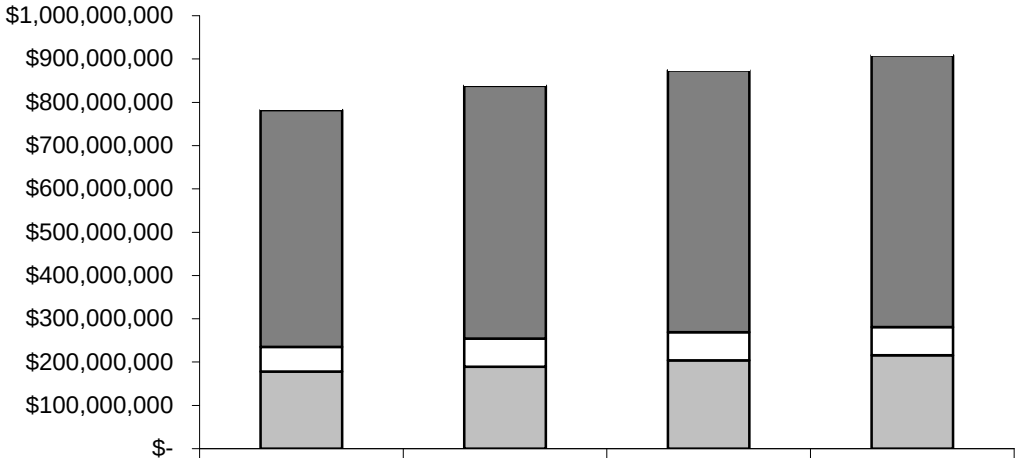
1983 - Department lost Boren Amendment lawsuit to Montana Health Care Association (Nursing Homes) for insufficient reimbursement rates. Financial implications include: 1) retroactive payments for prior years; 2) increased reimbursement rates for subsequent years.

1982 - The HCBS waiver was implemented. This program consists of multiple services not traditionally offered to Medicaid recipients and designed to help people stay in their own homes rather than moving to an institution.

1982 - Prospective reimbursement system was instituted for the Nursing Home program.

EXPENDITURE PROJECTIONS

Projected State Funds Expenditures in Millions:



	SFY 2008	SFY 2009	SFY 2010	SFY 2011
Total Projected Expenditures	$781,616,311	$838,297,794	$873,557,943	$908,579,095
Federal Funding	$546,348,283	$583,979,370	$604,743,782	$627,707,478
State Special Revenue	$57,377,421	$65,401,132	$65,165,117	$65,317,735
State General Fund	$177,890,607	$188,917,293	$203,649,044	$215,553,882

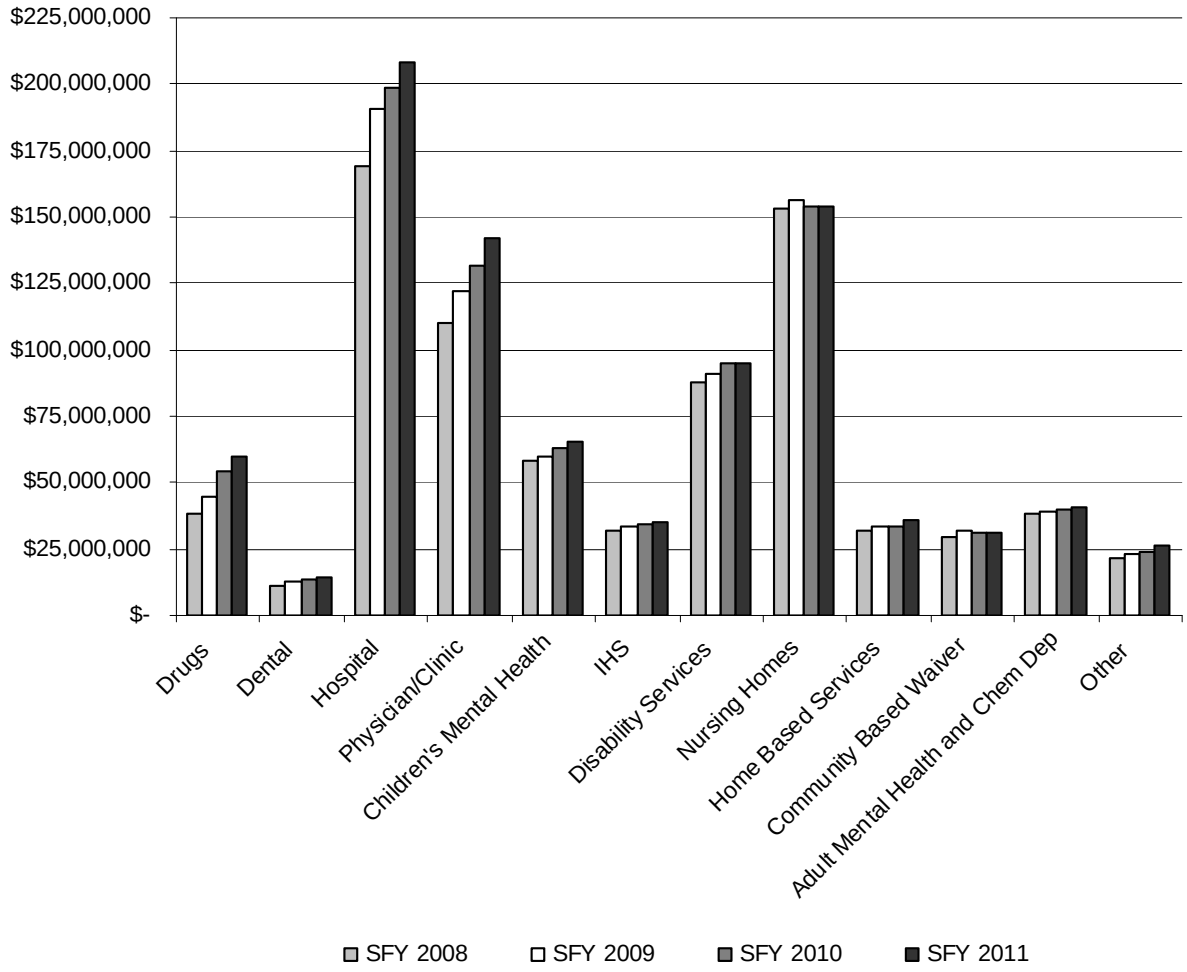
State Fiscal Year 2008 is based on projections as of November 2008.

State Funds Percentages of Medicaid

State Fiscal Year	**2008**	**2009**	**2010****	**2011****
Federal Match Rate	68.59%	68.08%	67.49%	67.03%
State Funds Percentage	31.41%	31.92%	32.51%	32.97%

** Estimates

Projected Benefit Expenditures by Provider Type



Provider Type	SFY 2008	SFY 2009	SFY 2010	SFY 2011
Drugs	$ 38,100,331	$ 44,828,007	$ 54,332,035	$ 59,918,725
Dental	$ 11,263,160	$ 12,493,243	$ 13,381,897	$ 14,333,762
Hospital	$ 168,872,674	$ 190,477,963	$ 198,928,530	$ 207,958,719
Physician/Clinic	$ 110,460,794	$ 122,146,032	$ 131,755,601	$ 142,066,611
Children's Mental Health	$ 58,047,977	$ 59,884,086	$ 62,819,731	$ 65,687,209
IHS	$ 32,256,582	$ 33,224,279	$ 34,221,008	$ 35,418,743
Disability Services	$ 88,128,451	$ 90,987,574	$ 94,890,633	$ 94,890,633
Nursing Homes	$ 153,303,551	$ 156,732,031	$ 154,343,116	$ 153,895,208
Home Based Services	$ 32,011,168	$ 33,614,475	$ 33,890,834	$ 35,633,794
Community Based Waiver	$ 29,855,184	$ 31,652,104	$ 31,130,105	$ 31,130,105
Adult Mental Health and Chem Dep	$ 37,931,380	$ 39,384,774	$ 39,588,927	$ 40,939,955
Other	$ 21,385,059	$ 22,873,226	$ 24,275,526	$ 26,705,631
Total	$ 781,616,311	$ 838,297,794	$ 873,557,943	$ 908,579,095

State Fiscal Year 2008 is based on projections as of November 2008. Prescription expenditures have been reduced by rebates. No provision for projections for new SDMI waiver for adults.

GLOSSARY OF ACRONYMS

ACS: Affiliated Computer Services (previously Consultec)

AFDC: Aid to Families with Dependent Children

AMDD: Addictive and Mental Disorders Division

APC: Ambulatory Payment Classification

CAHRD: Child and Adult Health Resources Division (now Health Resources Division)

CD: Chemical Dependency

CFSD: Child and Family Services Division

CHIP: Children's Health Insurance Plan

CMS: Centers for Medicare and Medicaid Services (replaced HCFA)

CPI: Consumer Price Index

DD: Developmental Disabilities

DPGs: Day Procedure Groups

DRAMS: Drug Rebate Analysis and Management System

DRG: Diagnosis Related Group

DSD: Disability Services Division

EFE: Essential For Employment

EPSDT: Early and Periodic Screening, Diagnosis, and Treatment

FAIM: Families Achieving Independence in Montana

FFS: Fee-for-Service

FMAP: Federal Medical Assistance Percentage (the Federal reimbursement percentage for approved medical services)

FPL: Federal Poverty Level

FQHC: Federal Qualified Health Center

FY: Fiscal Year (state FY is July 1—June 30; federal FY is October 1—September 30)

HCFA: Health Care Financing Administration (now Centers for Medicare and Medicaid Services – CMS)

HCBS: Home and Community Based Services

HCPI: Health Care Price Index

HCSD: Human and Community Services Division

HMO: Health Maintenance Organization

HRD: Health Resources Division

ICF/MR: Intermediate Care Facility for Mental Retardation

IHS: Indian Health Services

IMD: Intermediate Care Facility for Mental Disease

MCDC: Montana Chemical Dependency Center

MDC: Montana Developmental Center (ICF/MR)

MH: Mental Health

MHO: Mental Health Organization

MMHNCC: Montana Mental Health Nursing Care Center

MMIS: Medicaid Management Information System

MSH: Montana State Hospital (IMD)

NDC: National Drug Code

NH: Nursing Home

OBRA: Omnibus Budget Reconciliation Act

PAS: Personal Assistance Services

PD: Physically Disabled

QAD: Quality Assurance Division

RBRVS: Resource-Based Relative Value Scale

RHC: Rural Health Clinic

RVU: Relative Value Unit

SAMHSA: Substance Abuse and Mental Health Services Administration

SDMI: Severe and Disabling Mental Illness

SED: Serious Emotional Disturbance (children and adolescents)

SFY: State Fiscal Year (July 1—June 30)

SLTC: Senior and Long Term Care Division

SSI: Supplemental Security Income

TANF: Temporary Assistance for Needy Families